CENTRAL FLORIDA GASTROENTEROLOGY

PATIENT INFORMATION - INFORMACION DEL PACIENTE

PATIENT NAME NOMBRE DEL PACIENTE				BIRTHDATE FECHA DE NACIMIENTO	SEX SEXO
ADDRESS DIRECCION	CITY CIUDAD	STATE ESTADO	ZIP CODE ZIP CODE	SOCIAL SECURITY NUMBER NUMERO DE SEGURO SOCIAL	MARITAL STATUS ESTADO CIVIL ☐ SINGLE ☐ SOLTERO(A) ☐ MARRIED ☐ CASADO(A) ☐ DIVORCED ☐ DIVORCIADO(A) ☐ WIDOWED ☐ VIUDO(A)
HOME PHONE TELEFONO DE CASA	CELL PHONE TELEFONO CELULAR	EMAIL EMAIL		REFERRING PHYSICIAN MEDICO REFERIDO	
EMPLOYER PHONE # TELEFONO DEL PATRÓN	EMPLOYER NAME & ADDRESS PATRON & DIRECCION		ARE YOU DISABLED ESTÁ USTED INCAPACITADO ☐ YES ☐ NO	DATE OF DISABILITY FECHA DE INCAPACIDAD	
SPOUSE/GUARDIAN NOMBRE DEL ESPOSO(A) / NOMBRE DEL CUSTIDIO	EMPLOYER PATRÓN		EMPLOYER PHONE # TELEFONO DEL PATRÓN		
EMERGENCY CONTACT CONTACTO DE EMERGENCIA	ADDRESS DIRECCION		PHONE TELEFONO		

FOR REPORT PURPOSES ONLY: RACE _____ **ETHNICITY** _____ **LANGUAGE** _____

PRIMARY INSURANCE INFORMATION - INFORMACION PRIMARIA DEL SEGURO

NAME OF INSURANCE COMPANY NOMBRE DE COMPAÑIA DE SEGURO		ADDRESS DIRECCION		PHONE TELEFONO
EFFECTIVE DATE FECHA VIGENTE	PATIENT'S INS. ID # SEGURO DEL PACIENTE ID #	GROUP NAME NOMBRE DEL GRUPO	GROUP NUMBER NUMERO DE GRUPO	
NAME OF SUBSCRIBER NOMBRE DEL SUSCRIPTOR	SOCIAL SECURITY NUMBER OF SUBSCRIBER NUMERO DE SEGURO SOCIAL DEL SUSCRIPTOR	BIRTHDATE OF SUBSCRIBER FECHA DE NACIMIENTO DEL SUSCRIPTOR	RELATIONSHIP OF SUBSCRIBER TO PATIENT RELACIÓN DEL SUSCRIPTOR AL PACIENTE	

SECONDARY INSURANCE INFORMATION - INFORMACION DE SEGURO SECUNDARIO

NAME OF INSURANCE COMPANY NOMBRE DE COMPAÑIA DE SEGURO		ADDRESS DIRECCION		PHONE TELEFONO
EFFECTIVE DATE FECHA VIGENTE	PATIENT'S INS. ID # SEGURO DEL PACIENTE ID #	GROUP NAME NOMBRE DEL GRUPO	GROUP NUMBER NUMERO DE GRUPO	
NAME OF SUBSCRIBER NOMBRE DEL SUSCRIPTOR	SOCIAL SECURITY NUMBER OF SUBSCRIBER NUMERO DE SEGURO SOCIAL DEL SUSCRIPTOR	BIRTHDATE OF SUBSCRIBER FECHA DE NACIMIENTO DEL SUSCRIPTOR	RELATIONSHIP OF SUBSCRIBER TO PATIENT RELACIÓN DEL SUSCRIPTOR AL PACIENTE	

LIFETIME AUTHORIZATION FOR INSURANCE ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE - AUTORIZACION POR VIDA PARA ASIGNACION DE BENEFICIOS Y LIBERACION DE INFORMACION

I hereby give consent to Internal Medicine Specialists to provide whatever treatment they deem necessary to the patient named above. I authorize any insurance company, organization, employer, hospital, physician, dentist or pharmacist to release any information requested with regard to obtain authorization for future treatment and with regard to processing claims.

I certify the information I furnish is true and correct and that I know it is a crime to fill out this form with facts that I know are false or to leave out facts that I know are important.

I assign payment directly to the physicians, nurse practitioners, or physician assistants at Internal Medicine Specialists which may be due to me from the Medicare program or other health insurance company. I understand I am financially responsible to Internal Medicine Specialists for any non-covered insurance services.

Patient or Responsible Party:_____ Date:_____

All necessary lab work will be billed separately by an independent laboratory. Please notify nurse of special laboratory requirements.

Por este medico doy mi concentimiento a Internal Medicine Specialists para proveer cualquier tratamiento que ellos estimen necesario al paciente en referencia. Autorizo cualquier compañia de seguro, organizacion, patrono, hospital, medico, dentista o farmaceutico a liberar cualquier informacion requerida para obtener autorizacion para futuro tratamiento y processamiento de reclamos.

Yo certifico que la informacion que estoy dando es cierta y correcta y que estoy conceinte que es una violacion de ley proveer informacion falsa y/o de informar informacion intencionalmente sabiendo que es importante.

Yo assigno pago directo a los medicos, enfermeras practicante (nurse practitioners) y/o assistentes medicos en Internal Medicine Specialists que pueden estar debiendome del programa de medicare o cualquier otra compania de serguro. Yo entiendo que soy responsible por cualquier deuda financiera a Internal Medicine Specialists por todo servicio no cubierto por servicios de seguro.

Paciente o persona responsible_____ Fecha _____

Todo trabajo de laboratorio sera facturado por separado por el laboratorio independiente. Favor de notificarle a la enfermera se cualquier requerimiento especial de laboratorio.

COMMERCIAL INSURANCE - SEGURO COMERCIAL

I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to the doctor or group indicated on the claim. I understand I am financially responsible for any balance not covered by my insurance carrier. A copy of this signature is as valid as the original.

Payment is requested at time of service for self pay patients. A bookkeeper can assist you if arrangements must be made. We will be glad to assist with insurance forms. Your policy and coverage is a contract between you and your insurance company. You are responsible for all payments.

Yo autorizo que se ofresca la información necesaria para así someter un reclamo con mi compañía de seguro y qué los beneficios sean asignados a mi o de otro modo a mi doctor o el grupo indicado en la forma del seguro. Yo tengo entendido que yo soy responsable por cualquier balance que mi seguro no cubra. Una copia de esta firma es valida como la original.

El pago es requerido al tiempo que se rinden los servicios a todo paciente no asegurado. Alguien de nuestro departamento de seguro puede asistirle si necesita un arreglo de pagos mensuales. Nosotros podemos asistirle en llenar las formas para su seguro. Su poliza de seguro es un contrato entre usted y la compañia de seguro. Usted es responsable de los pagos.

Signature / Firma_____ Date / Fecha_____

Witness / Testigo_____ Date / Fecha_____

FOR OFFICE USE ONLY	CHART #:	INITIALS:	PERCENT NEEDED? ☐ YES ☐ NO	COPAY:	AUTHORIZATION NUMBER:

108300 (1/11)

CENTRAL FLORIDA GASTROENTEROLOGY

PATIENT NAME: _____ TODAY'S DATE: _____

Reason for your visit today: _____

Are you allergic to any medications? _____ Which ones? _____

	PREVIOUS TESTS	When	Ordering physician	Results
	Colonoscopy			
	EGD			
	CT abdomen/pelvis			
	Ultrasound/MRI			
	Liver biopsy			
	Other			

MEDICAL PROBLEMS (if yes, place check mark to the *right* of the condition)

Have you ever received chemo, radiation therapy or other treatment for a condition?

High blood pressure ____	Arthritis ____	Macular Degen. ____	Blood Clots ____
Diabetes ____	Asthma ____	Anemia ____	Cancer: ____
High cholesterol ____	Atrial fibrillation ____	Gout ____	HIV ____
Angina (chest pain) ____	BPH (enlarged prostate) ____	Bladder issues ____	Hepatitis B ____
Heart attack ____	COPD ____	Sleep apnea ____	Hepatitis C ____
Heart murmur ____	Thyroid problems ____	Liver problems ____	Crohn's ____
Stroke ____	Epilepsy ____	Kidney problems ____	Celiac ____
Heart problems ____	Glaucoma ____	Lung problems ____	Colitis ____
Allergies ____			

SURGERIES *(place an "x" next to all that apply)*

	MO/YR			MO/YR	
		Appendectomy (appendix)			Hip replacement
		Breast (mastectomy, augmentation)			Hysterectomy
		Back surgery			Knee (replacement, arthroscopy)
		Cataract			Open Heart # bypass:
		C-section how many?:			Valve replacement
		Gallbladder			Pacemaker
		Gastric bypass			Plastic surgery
		Hemorrhoidectomy			TURP
		Hernia repair			
		Other:			

HOSPITALIZATIONS

Dates (mo/yr)	Hospital	Reason

FAMILY HISTORY *(please circle your response and complete the question)*

Any family history of colon cancer, stomach cancer, polyps or GI diseases?				Y or N If:
Father: alive / deceased	Age:	Health problems/cause of death:		
Mother: alive / deceased	Age:	Health problems/cause of death:		
Sisters/Brothers: # Brothers ___	# Sisters ___		Are they healthy?	Y or N
Children: Sons ___	Daughters ___		Are they healthy?	Y or N

SOCIAL HISTORY *(place an "x" and give complete answers to all that apply)*

Marital Status: __ married __ divorced __ single __ widowed __ separated __ life partner

Blood transfusion	Y or N	If yes, when? Date(s):
Cocaine use		
Recreational drug use		Never / Current / Past Type(s):
IV Drug Use		Never / Current / Past
TATTOOS		How many?: Year they were done:
Sexually active		
Birth Place		Where:
Nursing Home resident		
Occupation		What do you do?
Tobacco		How many packs per day?
QUIT tobacco use		After how many years: How many packs per day?
Alcohol		How much per day?
Caffeine		How many cups coffee, cola or tea per day:
Travel outside US		Where:
Occupational exposure		What type:
Jehovah's Witness		
What is your birth year?		Have you ever been tested for Hepatitis C?

HISTORY & PHYSICAL (*place an "X" next to any symptoms that you are currently experiencing)*

Itchy eyes ____
Runny nose ____
Scratchy throat ____
Sinus congestion ____
Allergic reactions ____
_____
Moles ____
Rash ____
Hives ____
Hair loss ____
_____
Blurred vision ____
Eye irritation ____
_____
Nosebleeds ____
Shortness of breath ____
Vocal changes ____
Cough ____
_____
Chest pain ____
Leg swelling ____
Palpitations ____
_____
Abdominal pain ____
Rectal bleeding ____
Change in bowel habit ____

Weight loss ____
Nausea ____
Vomiting ____
Heartburn ____
Indigestion ____
Difficulty swallowing ____
Painful swallowing ____
Constipation ____
Diarrhea ____
Abnormal distension ____
Blood in stool ____
Vomiting blood ____
Black, tarry stools ____
Anal discomfort ____
Bloating ____
Gas ____
Hiccups ____
Stool incontinence ____
Fatigue ____
Feeling full early ____
Loss of appetite ____
Fever ____
Sclera ____
Edema ____
Flatulence ____
Jaundice ____

Hemorrhoids ____
_____
Blood in urine ____
Difficulty urinating ____
Frequent urination ____
Headache ____
Insomnia ____
Seizures ____
_____
Memory loss ____
Considering suicide ____
Depression ____
Anxiety ____
Sleep disturbances ____
_____
Joint pain ____
Leg cramps ____
Gout ____
_____
Heat intolerance ____
Excessive thirst ____
Excessive sweating ____
_____
Bleeding or bruising ____
Anemia ____
Past transfusion ____

CENTRAL FLORIDA GASTROENTEROLOGY

CURRENT MEDICATIONS

Patient Name: _____ Date: _____
Nombre de Paciente Fecha

Pharmacy Name: _____ Pharmacy Phone #: _____
Nombre de Farmacia Numero de la Farmacia

Preferred Lab Facility: _____ Lab Phone #: _____
Nombre de Laboratorio Numero de la Laboratorio

Have you taken any over-the-counter medication and/or prescription medication for heartburn in the past? (i.e., Protonix, Prilosec, TUMs, omeprazole, Nexium, Aciphex, etc.) YES or NO
If yes, please list: _____

Please list all current medication, including strength and dose.
Favor de incluir todo medicamento con los miligramos y dosis.

MEDICATION Medicacion	STRENGTH Miligramos	DOSE Dosis

I, _____, give permission for Dr. Richard Dumois to obtain my prescription history for the past (2) years. This information will be kept in my confidential medical records.

X _____
Patient Signature

NEPHROLOGY CONSULTANTS
CENTRAL FLORIDA GASTROENTEROLOGY
a division of internal medicine specialists
3885 Oakwater Circle • Orlando, FL 32806 • 407-851-5600 • Fax: 407-438-9561

CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

The Patient hereby consents to the use or disclosure of his/her individually identifiable health information ("protected health information") and patient medical record information by **Internal Medicine Specialists, Inc.** (the "Practice") in order to carry out treatment, payment, or health care operations. The Patient should review the Practice's Notice of Privacy Practices for a more complete description of the potential uses and disclosures of such information, and the Patient has the right to review such Notice prior to signing this Consent Form.

The Practice reserves for itself the right to change the terms of its Notice of Privacy Practices at any time. If the Practice does change the terms of its Notice of Privacy Practices, Patient may obtain a copy of the revised Notice.

Patient retains the right to request that the Practice further restrict how his/her protected health information is used or disclosed to carry out treatment, payment, or health care operations. The Practice is not required to agree to such requested restrictions; however, if the Practice does agree to Patient's requested restriction(s), such restrictions are then binding on the Practice.

Patient acknowledges and agrees that the Practice may disclose Patient's protected health information and patient medical record information to the following individuals who are either the Patient's family members, legal representatives, guardian, health care surrogates, or have power of attorney on behalf of the Patient: **(Patient must fill out) Name/Relationship:**_____

_____

_____

The Patient agrees that the Practice may disclose the following types of information contained in the Patient's medical records (please **initial, do not check,** the appropriate categories listed below):

	Restrictions		Restrictions
_____	HIV/AIDS Information	_____ Mental Health Information	
_____	Substance Abuse Information	_____ If Patient is under the age of eighteen (18), Pregnancy	
_____	Sexually Transmitted Disease Information	information	

Patient agrees and consents to the Practice releasing information to Patient in the following alternative manners (please **initial, do not check** the appropriate spaces below):

_____ Via e-mail to the Patient's designated e-mail address which is: _____.

_____ Via Regular Mail with any envelopes being marked personal and confidential and addressed to Patient.

_____ Via telephone, if Patient contacts the Practice and provides the appropriate information (including the Patient's name, social security number and date of birth.)

At all times, Patient retains the right to revoke this Consent. Such revocation must be submitted to the Practice in writing. The revocation shall be effective *except* to the extent that the Practice has already taken action in reliance on the Consent. If you revoke this consent, Internal Medicine Specialists will only continue to treat you on an emergency basis, and in that case for 30 days.

The Practice may refuse to treat Patient if he/she (or an authorized representative) does not sign this Consent Form. If Patient (or authorized representative) signs this Consent and then revokes it, the Practice has the right to refuse to provide further treatment to Patient as of the time of revocation (except to the extent that the Practice is required by law to treat individuals).

I HAVE READ AND UNDERSTAND THE INFORMATION IN THIS CONSENT. I MAY RECEIVE A COPY OF THIS CONSENT, AND I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS SEALED DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS.

Date:_____ Time:_____ AM / PM

_____ _____

Signature of Patient/Authorized Representative* Please Print Name

*Please explain Representative's Relationship to Patient and include a description of Representative's Authority to act on behalf of the Patient. Please attach proof of guardianship with a court document.

_____

_____

_____

CENTRAL FLORIDA GASTROENTEROLOGY
RICHARD DUMOIS, MD
TINA M. BRUEFACH, PA-C
A Division of Internal Medicine Specialists
6735 Conroy Road, Suite 214 – Orlando, Florida 32835
phone: (407) 395-7040 fax: (407) 395-7105

ACKNOWLEDGMENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our Notice before signing this form. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting us in writing.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations as described in our Notice. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Patient Name

(Print): _____

(Signature): _____

Date: _____

Witness: _____

PROCEDURE INSURANCE INFORMATION

Thank you for scheduling your upcoming appointment with Dr. Richard Dumois. Depending on the reason for your office visit, it is possible you will be asked to schedule a procedure. Therefore, please read and sign this form prior to coming in to see the doctor.

Please understand that there are four (4) separate charges, and you may receive up to four (4) different bills: One from the surgical center, one from Dr. Dumois for the physician's fee, one from the anesthesiologist, and one from the lab if a biopsy is performed.

If you schedule a procedure, please contact your insurance company to find out if you have a co-pay, co-insurance and/or deductible for outpatient surgery. Your colonoscopy and/or endoscopy is considered and billed as an outpatient surgical procedure. It is done at an outpatient surgical center, not in the doctor's office.

Unless prior arrangements are made, all co-pays, co-insurances and/or deductible balances for the surgery center are due in full on the day of your procedure. A billing fee will be charged to all accounts not paid in full at that time. Again, please contact your insurance company to determine the amount you will be responsible for. You can find the customer service telephone number on the back of your insurance card. If you have any questions after contacting your insurance company, please call Central Florida Surgical Center at (407) 656-2700 ext 223.

If you have been scheduled for a "screening" colonoscopy, this means that you have *no signs or symptoms*, and you have a set benefit for preventative screenings from your insurance company. However, if Dr. Dumois finds a polyp or abnormality during the procedure, your benefits may change and your insurance policy will pay differently. **A colonoscopy is a very safe procedure, but as with any medical procedure, complications can occur (including but not limited to bleeding, infection, side effect from conscious sedation/diprivan, perforation that may require surgery such as colectomy/colostomy, cardiorespiratory arrest, spleen laceration, or aspiration pneumonia). There is also a 5% rate of missing colon cancer with a colonoscopy.** Alternative screening methods, such as air contrast barium enema and computed tomographic colonography, are available.

Please call Dr. Dumois' office at (407) 395-7040 if you must cancel your procedure**. It is important that you let us know at least 48 business hours in advance in order to avoid the $75 cancellation fee.** We ask that you please give us the same courtesy when canceling an office visit. You will be charged $25 for no-showing an office visit. We *do not accept cancellation messages left with the evening answering service*; therefore, please contact the office during normal business hours or leave your message at (407) 395-7040 extension 1503.

I acknowledge that I have read the above statement and will be responsible for my deductible, co-pay, and out-of-pocket expenses in the event that my scheduled screening examination does result in a procedure with a polyp or abnormality.

_____

Print Patient Name | Date of Procedure

_____ _____

Patient Signature | Date of Signature

CENTRAL FLORIDA GASTROENTEROLOGY

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____

SS#: _____ DOB: _____

Address: _____

This is a request to:

_____
Physician/facility

☐ *receive records from:*

_____
Address

_____
City, State, Zip

_____ _____
Phone *Fax*

☐ *release records to:*

RICHARD DUMOIS, MD
6735 CONROY ROAD, SUITE 214
ORLANDO, FL 32835
PHONE: (407) 395-7040 FAX: (407) 395-7105

This document authorizes the release of all medical records in your possession regarding care and treatment of above mentioned patient. Please send records pertaining to the following:

_____

I understand these records may contain information from other health care providers as well as information that is administrative in nature.

I specifically consent to the release of any information contained in the medical records which may relate to: (please place initials by statement(s) that apply to you)

____ Infections with human immunodeficiency virus (HIV)

____ Mental health issues and any other related alcohol or substance use

I understand that you have no responsibility for the use or distribution of this information by the party to whom it is released. I release you from all liability which may arise from your compliance with this request to release records.

I authorize you to transmit this information by facsimile transmission (fax) and/or mail, and thereby release you from any liability for breach of confidentiality, misdirection of transmission, or failure to receive transmission if my records are transmitted by fax.

This release is valid until revoked by written notice to Internal Medicine Specialists, P.A. at 11140 West Colonial Drive, Suite #3, Ocoee, Florida 34761.

_____ _____
Patient/Legal Representative Signature Date

_____ _____
Witness Signature Date