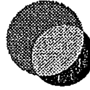
CENTRAL FLORIDA  **GASTROENTEROLOGY**

a division of internal medicine specialists

Name/*Nombre:* ________________________________ Date/*Fecha:* ________________

Primary Care Physician/*Doctor de cabezera:* ________________________ Age/*Edad* ________

List all physicians that have treated you./*Escriba el nombre de todos los doctores que le han atendido*

______________________________ ______________________________

______________________________ ______________________________

Current Medications/*Medicinas que toma actualmente*

____

____

____

____

____

Allergies to Medications/*Alergias a Medicinas*

____

____

____

____

____

Chief Complaints/*Principales Quejas*

____

____

____

____

____

Past Medical History/*Historia Medica*

_____ High Blood Pressure/*Presion Alta*

_____ Strokes/*Derrames Cerebral*

_____ Diabetes/*Diabetis*

_____ Insulin/*Insulina* _____ Pills/*Pastillas*

_____ High Cholesterol/*Colesterol Elevado*

_____ Heart Attacks/*Ataques del corazon*

_____ Angina/*Dolor del pecho*

_____ Congestive Heart Failure/*Insuficiencia Cardiaca*

_____ Smoker's Lung/*Enfermedades del Pulmon*

_____ Asthma/*Asma*

_____ Prostate Problems/*Problemas de las Prostata*

_____ Thyroid Problem/*Problemas de la Tiroide*

_____ Seizures/*Ataques Epilepticos*

_____ Cancer

_____ Depression/*Depresion* _____ Anxiety/*Ansiedad*

_____ Arthritis/*Artritis*

_____ Other ______________________________

Past Surgical History/*Historia de Cirugia*

_____ Heart Catheterization/*Cateterizacion del Corazon*

_____ Open Heart Surgery/*Cirugia de Corazon Abierto*

_____ Appendix Surgery/*Cirugia de la Apendice*

_____ Major Physical Trauma/*Traumatismo Fisico Intenso*

_____ Other ______________________________

_____ Eye Laser Surgery/*Cirugia Laser del Ojo*

_____ Gallbladder/*Vesicula*

_____ Hysterectomy/*Histerectomia*

_____ Carotid Surgery/*Cirugia de la Carotida*

Doctor's Notes

____

____

I ______________________________ (print name) give permission for Internal Medicine Specialists to obtain my prescription history for the past (2) years. This information will be kept in my confidential medical records.

x ______________________________ signature

Family History (Check if applies) ***Historia Familiar*** *(marque si aplica)*

_____ Diabetes/*Diabetis*
_____ Family member on kidney machine (dialysis)
Miembro familiar en maquina de riñon (dialisis)
_____ High blood pressure/*Presion Alta*
_____ Heart Disease/*Problemas del Corazon*
_____ Colon Cancer/*Cancer del Colon*
_____ Stroke/*Derrame Cerebral*
_____ Cancer
_____ Polyps
_____ Crohn's Disease or Ulcerative Colitis
_____

Have you ever smoked? ☐ No ☐ Yes
Do you currently smoke? ☐ No ☐ Yes
*If yes, how much?*_____________
Usted fuma? ☐ *No* ☐ *Si Cuanto?*______
Do you consume alcohol? ☐ No ☐ Yes
*If yes, how much?*_____________
Bebe bebidas alcolicas? ☐ *No* ☐ *Si*
*Cuanto?*_____________
Any history of illicit drugs? ☐ No ☐ Yes
Cual quier historia de drogas ilícitas?
☐ *No* ☐ *Si*
Any history of IV drugs? ☐ No ☐ Yes

Do you take/*Usted toma* _____Aspirin _____ Advil _____ Motrin _____ Aleve _____ Nuprin _____ Coumadin

Symptoms you are having or have had recently/*Sintomas que esta teniendo o ha tenldo recientement*

Heart/*Corazon*
_____chest pain with activity/*dolor de pecho con actividad*
_____chest pain at rest/*dolor de pecho descansando*
_____swelling of legs/*plernas hinchadas*
_____palpitations/*palpitaciones*
_____dizziness/*mareo*

Urinary Problems/*Problemas Urinarlos*
_____getting up to urinate at night/*levantandose a orinar por las noches*
_____frequency/*frecuentemente*
_____blood in urine/*sangre en la orina*
_____burning on urination/*ardor al orinar*

Respiratory/*Respiratorio*
_____chronic cough/*toz cronica*
_____shortness of breath/*falta de aire*

Muscoloskeletal Problems/*Problemas Musculares*
_____joint pain/*dolor en la articulacion (coyuntura)*
_____gout/*gota*

Eyes/*Ojos*
_____blurry vision/*vision borrosa*
_____eye pain/*dolor de ojo*

Gastrointestinal Problems/*Problems Gastrointestinales*
_____constipation/*estreñimiento*
_____diarrhea/*diarrea*
_____blood in stool/*sangre en las heces fecales*
_____vomiting/*vomito*
_____bloating/*ilenura*
_____abdominal pain/*dolor abdominal*

Skin/*Piel*
_____rash/*irritacion de la piel*
_____itching/*picazon*

Allergy Problems/*Problemas de alergia*
_____hives/urticaria
_____allergic reaction/*reaccion alergica*

Questions for the doctor or nurse/*Preguntas para el doctor o enfermera*
1. ____________________
2. ____________________
3. ____________________

Additional Information

____
____
____
____

CENTRAL FLORIDA GASTROENTEROLOGY

a division of internal medicine specialists

PATIENT INFORMATION - INFORMACIÓN 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 ☐ MARRIED ☐ DIVORCED ☐ WIDOWED / ☐ SOLTERO(A) ☐ CASADO(A) ☐ DIVORCIADO(A) ☐ VIUDO(A)

HOME PHONE / TELEFONO DE CASA
REFERRING PHYSICIAN / MEDICO REFERIDO
EMPLOYER / PATRON
ADDRESS / DIRECCIÓN

EMPLOYER PHONE # / TELEFONO DEL PATRÓN
ARE YOU RETIRED / ESTÁ USTED RETIRADO ☐YES ☐NO
DATE OF RETIREMENT / FECHA DE RETIRO
ARE YOU DISABLED / ESTÁ USTED INCAPACITADO ☐YES ☐NO
DATE OF DISABILITY / FECHA DE INCAPACIDAD
DO YOU HAVE INSURANCE / TIENE USTED SEGURO ☐YES ☐NO

SPOUSE/GUARDIAN / NOMBRE DEL ESPOSO(A) / NOMBRE DEL CUSTIDIO
EMPLOYER / PATRÓN
EMPLOYER PHONE # / TELEFONO DEL PATRÓN

NEAREST RELATIVE NOT LIVING WITH YOU / NOMBRE DE OTRO FAMILIAR QUE NO VIVA CON USTED
RELATIONSHIP / RELACION
ADDRESS / DIRECCIÓN
PHONE / TELEFONO

EMERGENCY CONTACT / CONTACTO DE EMERGENCIA
ADDRESS / DIRECCIÓN
PHONE / TELEFONO

PRIMARY INSURANCE INFORMATION - INFORMACION PRIMARIA DEL SEGURO

NAME OF INSURANCE COMPANY / NOMBRE DE COMPAÑIA DE SEGURO
ADDRESS / DIRECCIÓN
PHONE / TELEFONO

EFFECTIVE DATE / FECHA VIGENTE
PATIENT'S INS. ID # / SEGURO DEL PACIENTE ID #
GROUP NAME / NOMBRE DEL GRUPO
GROUP NUMBER / NÚMERO DE GRUPO

NAME OF SUBSCRIBER / NOMBRE DEL SUSCRIPTOR
SOCIAL SECURITY NUMBER OF SUBSCRIBER / NÚMERO 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 / DIRECCIÓN
PHONE / TELEFONO

EFFECTIVE DATE / FECHA VIGENTE
PATIENT'S INS. ID # / SEGURO DEL PACIENTE ID #
GROUP NAME / NOMBRE DEL GRUPO
GROUP NUMBER / NÚMERO DE GRUPO

NAME OF SUBSCRIBER / NOMBRE DEL SUSCRIPTOR
SOCIAL SECURITY NUMBER OF SUBSCRIBER / NÚMERO 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 ·em necessary to the patient named above. I authorize any insurance company, organization, ·nployer, hospital, physician, dentist or pharmacist to release any information requested with re- ·rd 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 ·h 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 **Inter- ·l Medicine Specialists** which may be due to me from the Medicare program or other health ·urance company. I understand I am financially responsible to **Internal Medicine Specialists** for ·non-covered insurance services.

·ient or Responsible Party:______________ Date:______________

·necessary lab work will be billed separately by an independent laboratory. Please notify nurse ·pecial 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 compania 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 puedan estar debiendome del programa de medicare o cualquier otra compania de seguro. 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

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

·ayment is requested at time of service for self pay patients. A bookkeeper can assist you ·angements must be made. We will be glad to assist with insurance forms. Your policy and ·rage is a contract between you and your insurance company. You are responsible for all ·nents.

Yo autorizo que se ofresca la información necesaria para asi someter un reclamo con mi compañia 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.

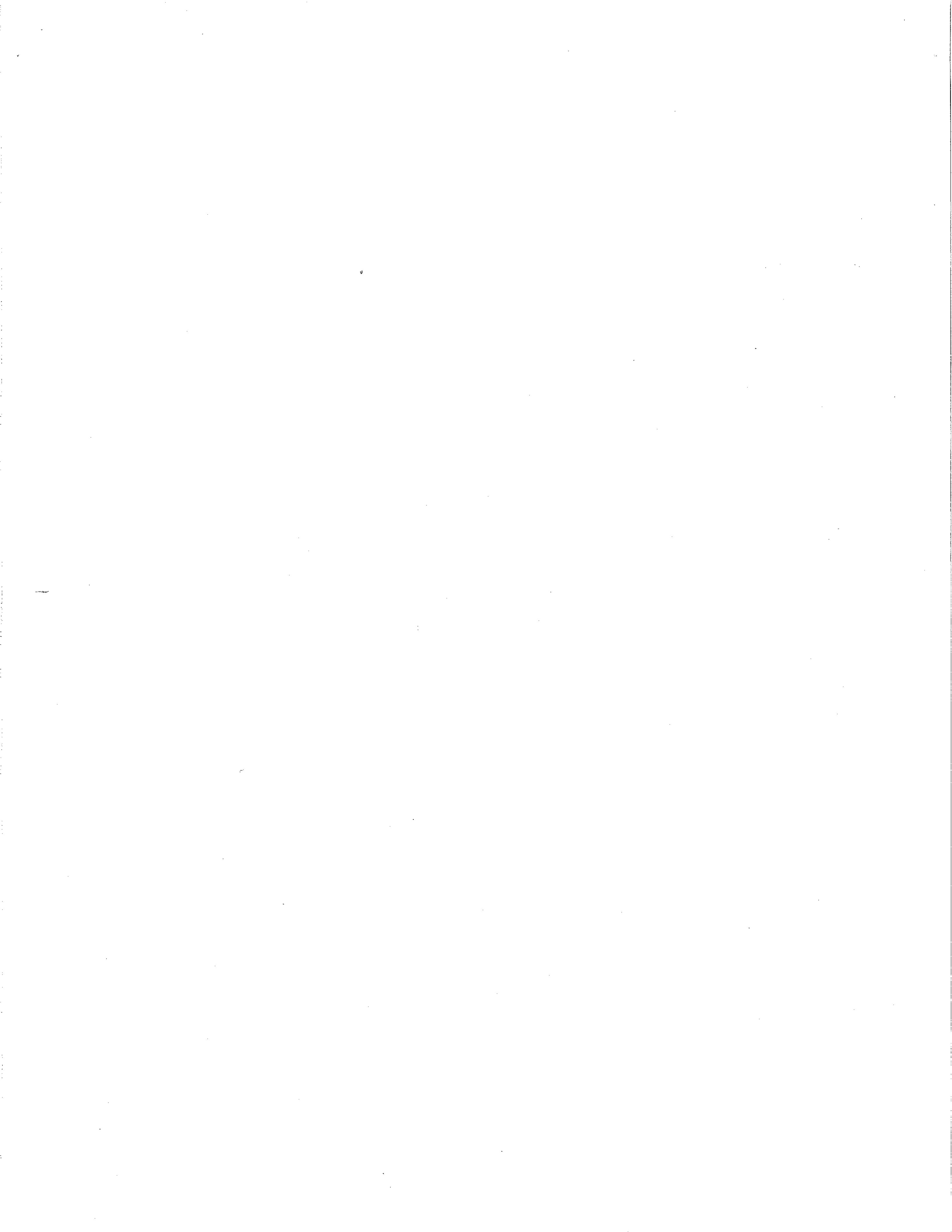
El pago es requerido al tiempo que se rinden los servicios a todo paciente no asegurado. Alguien de nuestro departamento de seguro puede asistirle si necesita un arreglo de pagos mensuales. Nosotros podemos asistirle en llenar las formas para su seguro. Su poliza de seguro es un contrato entre usted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

·ture / Firma ______________ Date / Fecha ______________

·ss / Testigo ______________ Date / Fecha ______________

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

(10/05)



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

________ HIV/AIDS Information ____________________

________ Substance Abuse Information ____________________

________ Sexually Transmitted Disease Information ____________

Restrictions

________ Mental Health Information ____________________

________ If Patient is under the age of eighteen (18), Pregnancy information ____________________

________ Research. Our practice may use and disclose your IHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IHI for research purposes. ________

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.)

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

'he Practice may refuse to treat Patient if he/she (or an authorized representative) does not sign this Consent Form. If Patient (or authorized ꞉presentative) 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 ꞉vocation (except to the extent that the Practice is required by law to treat individuals).

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

ɜte:____________ Time:__________ AM / PM

____________________________ ____________________________

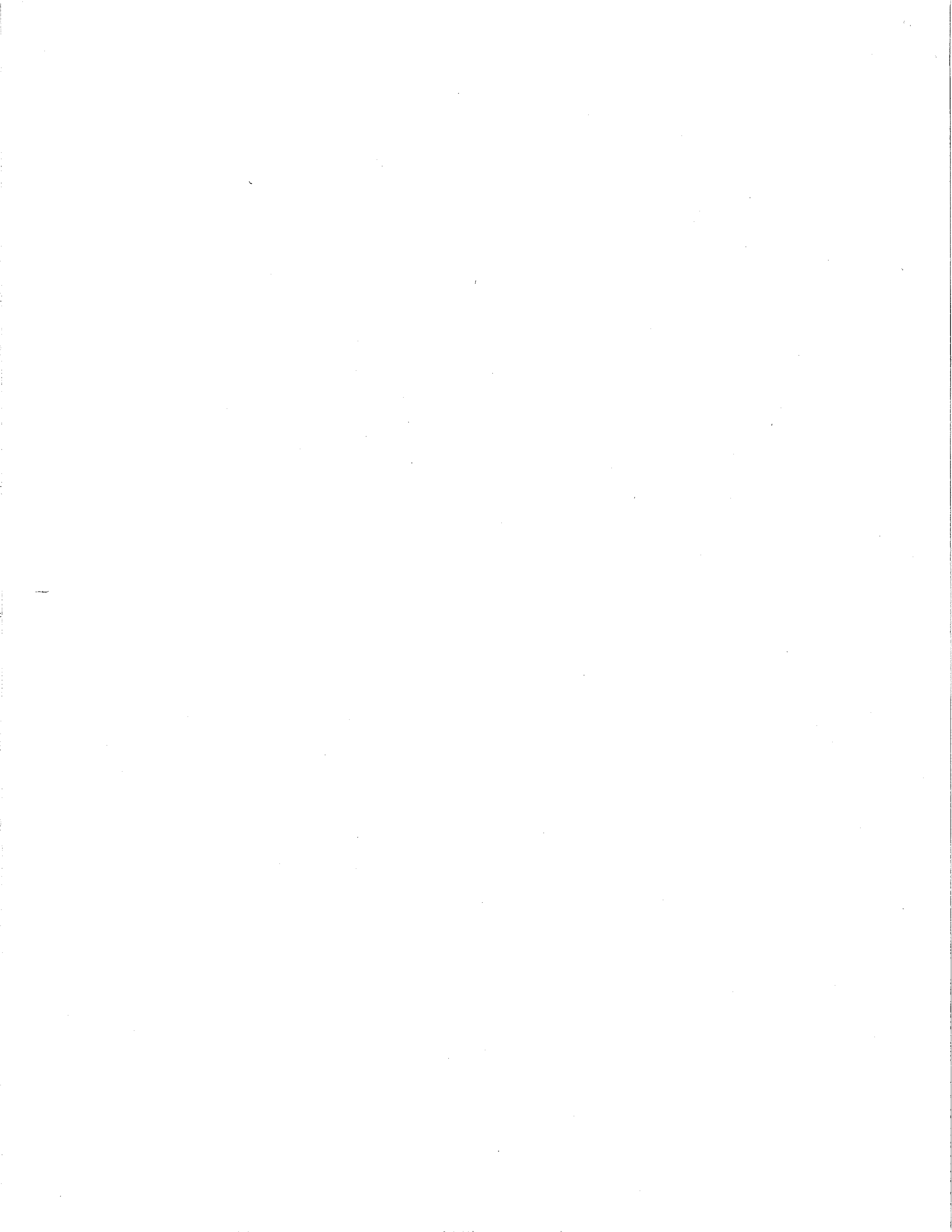
ʒnature of Patient/Authorized Representative* Please Print Name

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

____

____

____



Internal Medicine Specialists, Inc.
3885 Oakwater Circle
Orlando, FL 32806
407 851-5600
Fax# 407-438-9561

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: ______________________________

Rights and Respect for Property and Person

The patient has the right to:

Exercise his or her rights without being subjected to discrimination or reprisal

Voice grievance regarding treatment or care that is or fails to be furnished

Be fully informed about a treatment or procedure and the expected outcome before it is performed

Confidentiality of personal medical information

Privacy and Safety

The patient has the right to:

Personal privacy

Receive care in a safe setting

Be free from all forms of abuse or harassment

Advance Directives

You have the right to information on the Center's policy regarding Advance Directives.

Advance Directives will not be honored within the Center. In the event of a life-threatening event emergency medical procedures will be implemented. Patients will be stabilized and transferred to a hospital where the decision to continue or terminate emergency measures can be made by the physician and family.

If the patient or patient's representative wants their Advance Directives to be honored, the patient will be offered care at another facility that will comply with their wishes.

If you request, an official state Advance Directive Form will be provided to you.

Submission and Investigation of Grievances: You have the right to have your verbal or written grievances submitted, investigated and to receive a written notice of the Center's decision.

The following are the names and/or agencies you may contact:

CENTER DIRECTOR
2861 S. DELANEY AVE. SUITE B
ORLANDO, FLORIDA 32806
407-472-5095

You may contact your state representative to report a complaint;
www.cdc.gov

Sites for address and phone numbers of regulatory agencies: **Medicare Ombudsman website**
www.medicare.gov/Ombudsman/resources.asp

Medicare: www.medicare.gov or call 1-800-MEDICARE (1-800-633-4227)

Office of the Inspector General: http://oig.hhs.gov

Physician Financial Interest and Ownership: The Center is owned, in part, by the physicians. The physician(s) who referred you to this Center and who will be performing your procedure(s) may have a financial and ownership interest. Patients have the right to be treated at another health care facility of their choice. We are making this disclosure in accordance with Federal regulations.

By signing below, you, or your legal representative, acknowledge that you have received, read and understand this information (verbally and in writing) in advance of the date of the procedure and have decided to have your procedure performed at this center.

____

Signature of Patient or Patient Legal Representative

Date _____________

Patient Rights and Notification of Physician Ownership

Citrus Surgical Center
2861 S. Delaney Avenue Suite B
Orlando, Florida 32806
407-472-5095

Label for Medical Records

PLEASE BRING THIS FORM WITH YOU ON THE DAY OF YOUR PROCEDURE