Colon & Rectal Specialists

# Colon & Rectal Specialists, Ltd.
# Patient Registration

Last Name:_____

First Name:_____ Middle Initial:_____

Address:_____

City:_____State _____ Zip _____

Social Security:_____

( ) Male ( ) Female

Age _____ Date of Birth_____

Marital Status ( ) Single ( ) Married ( ) Divorced

( ) Widowed ( ) Separated ( )Partnered ( ) Other

Employment Status ( ) Full time ( ) Part time

( ) Self employed ( ) Retired ( ) Student

( ) Unemployment/Disability ( ) Other

Job Title_____

**Your Contact Information**

Home phone_____

Cell phone_____

Work phone_____

Fax #_____

Email_____

Preferred method of contact_____

**Guarantor (responsible for payment)**

( ) self ( ) spouse ( ) other

Last Name:_____

First Name_____ Middle Initial_____

Address_____

City_____State_____ Zip_____

Phone_____

**What is your preferred pharmacy?** ( ) none

Name_____

Address_____

City, State_____

Phone_____

**Primary Insurance**

Name of Plan_____

Group #_____

ID #_____

Subscriber: ( ) Self

( ) Spouse Name:_____DOB:_____

( ) Other Name:_____DOB:_____

**Secondary Insurance**

Name of Plan_____

Group #_____

ID #_____

Subscriber: ( ) Self

( ) Spouse Name:_____DOB:_____

( ) Other Name:_____DOB:_____

**Emergency Contact**

Name _____

Relationship to you_____

Phone # _____

Email_____

**Who is your primary care physician?** ( ) none

Full name_____

Specialty _____

Address_____

City, State_____

Phone #_____

**Which physician referred you to us?** ( ) I am self referred

Full name_____

Specialty _____

Address_____

City, State_____

Phone #_____

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# Colon & Rectal Specialists, Ltd.
# New Patient Medical and Surgical History

Date:_____ Patient Name:_____

Age: _____ Height:_____ Weight:_____ Sex: _____

What brings you in today?_____

_____

**PREVIOUS SURGICAL HISTORY:**

| Name/Type of Surgery | Date | Name/Type of Surgery | Date |
|---|---|---|---|
| 1. | | 5. | |
| 2. | | 6. | |
| 3. | | 7. | |
| 4. | | 8. | |

**PAST SERIOUS HOSPITALIZATIONS/ILLNESSES:** _____

_____

**OTHER CHRONIC MEDICAL PROBLEMS:**_____

_____

**CURRENT MEDICATIONS (please use back of page for additional medications):**

| Medication (include over the counter) | Dose | Medication (include over the counter) | Dose |
|---|---|---|---|
| 1. | | 6. | |
| 2. | | 7. | |
| 3. | | 8. | |
| 4. | | 9. | |
| 5. | | 10. | |

**DRUG ALLERGIES:**_____

_____

**MEDICAL HISTORY**

Have you ever had a colonoscopy? ☐ Yes ☐ No

If yes, date of your last colonoscopy:_____

| | | | | | |
|---|---|---|---|---|---|
| Diabetes | ☐ Yes | ☐ No | | | |
| Hypertension | ☐ Yes | ☐ No | Heart Attack | ☐ Yes | ☐ No |
| Congestive Heart Failure | ☐ Yes | ☐ No | COPD or Asthma | ☐ Yes | ☐ No |
| Stroke | ☐ Yes | ☐ No | Kidney Disease | ☐ Yes | ☐ No |

## SOCIAL HISTORY

Alcohol Use ☐ None ☐ Occasionally ☐ Daily: # of drinks/day_____

Tobacco Use ☐ Never ☐ Quit: Date_____ ☐ Occasionally ☐ Daily (Packs per day):_____

Recreational Drug Use ☐ None Type and Frequency _____

## FAMILY MEDICAL HISTORY

| | Current Age | Diseases | If Deceased, Cause of Death |
|---|---|---|---|
| Father | | | |
| Mother | | | |

Any family members with:

Colon or Rectal Cancer ☐ No ☐ Yes: Relationship _____

Colon or Rectal Polyps ☐ No ☐ Yes: Relationship_____

Inflammatory Bowel Disease (Includes Crohn's Disease or Ulcerative Colitis) ☐ No ☐ Yes: Relationship_____

## REVIEW OF SYSTEMS

Do you have or have had in the past any problems with the following (check all that apply)?

**General**

None ☐
Recent Weight Loss ☐
Fevers ☐

**Eyes**

None ☐
Vision Loss ☐
Eye Pain ☐

**Cardiovascular**

None ☐
Chest pain ☐
Irregular Heart Beat ☐

**Respiratory**

None ☐
Cough ☐
Shortness of Breath ☐

**Neurologic**

None ☐
Frequent Headaches ☐
Light headedness ☐

**Hematologic/Lymphatic**

None ☐
Enlarged Lymph Nodes ☐
Easy Bleeding ☐

**Genitourinary**

None ☐
Pain with Urination ☐
Urinary Incontinence ☐

**Musculoskeletal**

None ☐
Arthritis / Joint Pain ☐
Muscle Weakness ☐

**Skin**

None ☐
Rashes ☐
Genital Warts ☐

**Gastrointestinal**

None ☐
Abdominal Pain ☐
Changes in Bowel Habits ☐
Diarrhea ☐
Constipation ☐
Anal or Rectal Bleeding ☐
Anal Pain ☐
Anal Lump ☐
Anal Itching ☐
Fecal Incontinence/Accidents ☐
Fecal Urgency ☐
Describe any other GI symptoms _____

_____

_____

_____ _____

Patient Signature Date

Colon & Rectal Specialists

## CONSENT, DISCLOSURE AND AUTHORIZATION FORM

**Patient Name:**_____ **DOB:**_____

As used in this form, the words "I", "me", "my" and similar reference means the patient whose name appears above, or the parent, legal guardian or other legally responsible person on behalf of the minor or incapacitated patient named above.

### General Consent for Examination and Treatment

I hereby consent and authorize Colon and Rectal Specialists, Ltd., and all physicians and ancillary medical personnel of Colon and Rectal Specialists, Ltd., to perform medical examinations and provide routine medical care for all of my visits to Colon and Rectal Specialists, Ltd., including routine diagnostic and laboratory procedures and tests, medication administration, and other routine care for which a specified informed consent form will not be signed by me.

### Acknowledgement of Receipt of Notice of Privacy Practices

I have read and understand Colon and Rectal Specialists, Ltd., HIPAA Notice of Privacy Practices, which contains information on the uses and disclosures of my protected health information ("PHI"). I understand that I may also access a copy on the company's website at www.crspecialists.com.

### Consent to Use and Disclose Protected Health Information for Treatment, Payment and Health Care Operations

I hereby consent and authorize Colon and Rectal Specialists, Ltd., to use and disclose my health information, which includes all or any part of my medical record, by and to its workforce members, and to health care professionals, insurance companies, medical facilities, physicians and vendors, or suppliers involved, or who may become involved, with my treatment, the payment for my treatments and/or the health care operations of Colon and Rectal Specialists, Ltd. I understand that for example, my health information may be used or disclosed by Colon and Rectal Specialists, Ltd., to: provide for my care and treatment; communicate among various health care professionals who are involved in my care or treatment; bill for or obtain payment for care and treatment provided by Colon and Rectal Specialists, Ltd.; provide information to and obtain payment from my health insurance company or plan; assess and review the quality of my care; and conduct its business in health care operations. In addition, I understand that Colon and Rectal Specialists, Ltd., may release my protected health insurance as required by law or court order.

### Practice Policy for Administrative Services

I acknowledge that I have received, reviewed, understand and will comply with the following policies:

1. All checks returned for insufficient funds or a closed account will incur a $25 fee.
2. To obtain a copy of your medical records, you will be required to sign a Medical Release Form that is found on our website at www.crspecialists.com and return the form via fax to 804-249-2461. There is a processing fee of $10 plus $0.50 per page. These fees, set forth by Virginia State Law, must be paid in full before your request can be processed.
3. We can complete any forms such as FMLA or Disability by faxing them to 804-249-2461. The fee to complete these forms is $20 per form and must be paid in advance. Please allow 7-10 days for completion.

4. Surgical or Endoscopy procedures cancelled with less than five (5) business days notice will incur a fee of $100. For example, procedures scheduled on Monday have to be rescheduled or cancelled by calling our office at 804-249-2465 by the preceding Wednesday.

**Notice of Deemed Consent**

A law enacted in Virginia in 1989 authorizes health care providers to test their patients for HIV, Hepatitis B, and Hepatitis C antibodies when the health care provider is exposed to bodily fluids in a manner which they may, according to certain medical authority, transmit Human Immunodeficiency Disorder (HIV), the virus that causes Acquired Immunodeficiency Syndrome (AIDS) and related disorders, Hepatitis B or Hepatitis C viruses. Pursuant to this law, in the event of such an exposure, you will be deemed to have consented to such testing, and to have consented to the release of the test results to the health care provider who may have been exposed. However, if such exposure occurs, you will be informed before any of your blood is tested for HIV, HEP B or HEP C antibodies pursuant to this provision, the testing will be explained to you, and you will be give the opportunity to ask any questions you might have.

The law also provides that if you should be exposed to the bodily fluids of a health care provider in a manner which may, according to certain medical authority, transmit HIV, HEP B or HEP C, the health care provider is deemed to consent to such testing and to the release of the test results to you.

**Prescription Information**

Your physician may write you a prescription for a custom medication specific to your condition that is not commercially available. Therefore, it is not covered under insurance. You may either pick the prescription up at a designated RX3 pharmacy or have it delivered to your home. If you are a candidate for this type of medication, your physician will discuss it with you during your visit.

For all other commercial medication, we use E-Prescribe to the pharmacy of your choice. E- Prescriptions are computer generate prescriptions created by your provider and sent directly to your pharmacy through a HIPAA (Health Insurance Portability and Accountability Act) secure connection. The e-prescription is much faster and may save you time because you do not have to come into the office to pick up your written prescription. By signing this form you agree that Colon and Rectal, Ltd. may use e-prescribe and may request and use your prescription medication history from other health care providers or third-party pharmacy benefits payers for treatment purposes. This consent will remain in effect until the day that you revoke it. You may revoke this consent at any time in writing, but if you do, it will not have any effect on any actions taken prior to revoking the consent.

☐ Please use e-prescribe

☐ Please do not use e-prescribe. I want to come to the office and pick up a written prescription

**Disclosure to Authorized Individuals**

I understand that Colon and Rectal Specialists, Ltd., may release PHI to a family member, friend, or other person I indicate is involved in my care unless I object. I designate the following person (s) listed below as a person(s) involved with my health care and/or payment for my health care (circle as applicable(, to whom the information circled "yes" below may be released:

Name:_____ Relationship:_____
Address/Phone:_____

Health Info: Yes/No (circle as applicable) Payment Info Yes/No (circle as applicable)

List any health topics/information you do not want us to share with the above individual:

_____

Name:_____ Relationship:_____
Address/Phone:_____

Health Info: Yes/No (circle as applicable) Payment Info Yes/No (circle as applicable)

**Financial Waiver**

I understand that it is my responsibility to identify if my health insurance company requires a referral. I also understand that I am responsible for obtaining that referral prior to my visit. I agree that if I do not have the appropriate referral, that my health insurance company will not pay for my services and I agree to be financially responsible.

I also agree that if I do not present my health insurance card at the time of my visit or fail to give the office my correct insurance information that I agree to be financially responsible.

I also understand that if I do not have health insurance that I am considered "self pay" and that I am 100% financially responsible for the payment of the office visit, plus any additional procedures that may be performed during my visit.

I understand if I have an unpaid balance to Colon and Rectal Specialists and do not make satisfactory payment arrangements, my account may be placed with an external collection agency. I will be responsible for reimbursement of any fees from a collection agency, which may be based on a percentage at a maximum of 34% of the debt, and all costs and expenses, Including reasonable attorney's fees incurred in collection efforts

**SIGNED CONSENT AND AUTHORIZATION**

***I have read and understand the terms of this document. I had had an opportunity to ask questions about the use and disclosure of my health information and about the contents of this form. I acknowledge, consent and agree to the terms and conditions of this document:***

Patient Name:_____ Date:_____

Patient Signature:_____

Authorized Individual (Parent/Guardian) Name _____

Authorized Individual Signature _____

Relationship to Patient:_____

## Colon and Rectal Specialists, Ltd.
## Patient Rights and Responsibilities

Creating a positive patient experience is something we take seriously. You have rights and a role regarding your treatment and care. We will respect your rights and aim to help you understand your role as a partner in your care. Knowing your rights and responsibilities can help you make better decisions about your care.

### What are your rights as a patient?

### You have the right to:

- Be informed about the care you will receive.
- Get information about your care in your language.
- Make decisions about your care, including refusing care.
- Know the names of the caregivers who treat you.
- Safe care.
- Have your pain treated.
- Know when something goes wrong with your care.
- Get an up-to-date list of all of your current medicines.
- Be listened to.
- Be treated with dignity, courtesy and respect.
- Privacy and confidentiality regarding your medical records. No information will be released without your written consent.
- Information concerning fees for services we provide.
- Review and receive an explanation of your billing statement.
- Express concerns through our patient complaint program by contacting the Practice Administrator at 8700 Stony Point Parkway, Suite 270, Richmond, Va 23235 or 804-249-2465.
- Include advance directives in your medical record.
- Have your guardian, next of kin, or legal designee exercise these rights if you are unable to.

### What is your role in your health care?

- You should be active in your health care.
- Let us know if you do not understand, or cannot follow your health care instructions.
- You should ask questions. Be prepared with questions at the time of your visit.
- You should pay attention to the instructions given to you by your caregivers. Follow the instructions.
- You should share as much information as possible about your health with your caregivers. For example, give us an up-to-date list of your medicines, and remind us about your allergies.
- Notify us of any changes including name, address, phone number, employment, insurance, births, deaths or divorce.
- Call us as far in advance as possible to schedule an appointment.
- Give us 48-hour notice when you must cancel an appointment or 5 days if you must cancel a procedure
- Treat clinic physicians, staff and other patients with dignity, respect and courtesy.
- Know your health plan benefits.
- Pay your bill.
- Let us know how we are doing.