



Last Name: _____
First Name: _____ Middle Initial: _____
Address: _____
City: _____ State _____ Zip _____
Social Security: _____
() Male () Female () Other () Choose not to disclose
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 # _____



**Colon & Rectal
Specialists**

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

Date: _____ Patient Name: _____

Age: _____ Height: _____ Weight: _____ () Male () Female () Other () Choose not to disclose

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

Congestive Heart Failure Yes No

Stroke Yes No

Heart Attack Yes No

COPD or Asthma 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
Parent			
Parent			

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 given 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 regardless of race, color, religion, national origin, age, sex, sexual orientation, gender identity or expression, or disability.
 - 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.