COLON AND RECTAL
CLINIC OF ORLANDO

110 W Underwood St, Ste A
Orlando, Florida 32806
(407) 422-3790
(407) 425-4358 FAX

PAUL R. WILLIAMSON, M.D., FASCRS, FACS
ANDREA FERRARA, M.D., FASCRS, FACS
JOSEPH T. GALLAGHER, M.D., FASCRS, FACS
SAMUEL DEJESUS, M.D., FASCRS, FACS
RENEE J. MUELLER, M.D., FASCRS, FACS
JOSHUA KARAS, M.D., FACS
MARCO FERRARA, M.D, FACS

It is our pleasure to welcome you to the Colon & Rectal Clinic of Orlando in advance of your first visit.

Our business hours are 8:30am to 5:00pm. We practice at the following locations:

- ❑ **Downtown** 110 W. Underwood St. Orlando, FL 32806
- ❑ **Orlando North** 308 Groveland Street, Orlando, FL 32804
- ❑ **Health Central** 10000 W. Colonial Drive, Suite 382, Ocoee, FL 34761
- ❑ **Dr. Phillips Hospital** 9430 Turkey Lake Road, STE 118, Orlando FL 32819

Attached is a new patient registration packet. Please complete this paperwork and bring with you to your first appointment. Please also bring the following information with you for your visit:

- Proof of insurance cards
- Driver License
- Completed Patient Forms (attached)
- Form of payment

Payment Policy

It is our policy to collect the appropriate payment due from the patient at the time of service. This may be your co-payment, deductible or co-insurance. Please contact your insurance carrier to verify what your out-of-pocket may be.

- **Co-Payments**: The cost-sharing part of your bill that is a fixed dollar amount designated by your insurance company is called a co-payment. It is your responsibility to pay this co-payment prior to being treated by our physician.
- **Deductible**: The amount of cost-sharing that you must pay for medical services often before your health insurance will begin paying on your care. This amount varies per insurance carrier and policy so please call your insurance carrier. We expect that deductibles will be paid at time of service.
- **Co-Insurance**: This cost-sharing is generally a percentage of the total medical charge, for example 20% co-insurance. You will be responsible to pay your co-insurance at time of visit.

There are certain insurance plans that have all of the above. You may have a co-payment and a deductible and/or co-insurance and deductible. Please call your insurance company prior to visit if you have any questions.

Be aware that most often our physicians will perform a rectal exam with an anoscope or a flexible sigmoidoscope – these are done in our office as part of your exam and require no anesthesia; most insurance carriers are viewing this test as a procedure and this charge *will* go toward your deductible.

There will be a $50.00 no-show fee if you fail to cancel 24 hours prior to your appointment.

If you have questions after calling your insurance company, please call our office and we will be happy to assist you. Our business staff will do their best to inform you of your cost-sharing portion due to us before you are seen.

We appreciate your selecting the Colon & Rectal Clinic of Orlando and look forward to meeting you.

PREPARING FOR YOUR OFFICE VISIT

Purchase two Fleet enemas (see picture) from your local pharmacy or supermarket.

Two hours prior to leaving your home for your office visit, administer the first enema according to the instructions on the box.

After a bowel movement, wait ten minutes and administer the second enema.

You may eat as normal prior to your examination.

Do not take any laxatives or purgatives by mouth.

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Patient Information Sheet

Last Name: _____ First Name: _____ M.I.: _____

Address: _____ Home Phone: (_____)_____-_____

_____ Cell Phone: (_____) _____–_____

E-Mail: _____ Marital Status: _____

D.O.B.: _____/_____/_____ SS#: _____-_____-_____

Occupation: _____ Employer: _____

Hearing/Vision Impaired? _____ Primary Language: _____Translator Required? _____

Referring Physician: _____ Phone Number: (_____)_____-_____

Primary Care Physician: _____ Phone Number: (_____)_____-_____

Pharmacy Name: _____

Pharmacy Address: _____ Pharmacy Phone: (_____)_____-_____

_____

Emergency Contact(s)

Name: _____ Relationship: _____ Phone Number: (_____)_____-_____

Name: _____ Relationship: _____ Phone Number: (_____)_____-_____

Consent for Disclosure

It is often difficult to talk to patients in person. Therefore, we must have your permission as to how we may communicate with you. By filling out the below fields, you are giving the Colon & Rectal Clinic of Orlando authorization to disclose my personal medical information to the following individuals.

Name: _____Relationship: _____Phone: (_____)_____-_____

By signing this form, the practice may disclose information to me and to the above person by telephone, voicemail, facsimile, email, and/or regular mail.

Preferred Method of Communication: ☐ Telephone ☐ Email ☐ Text Message

Patient Signature: _____Date: _____

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Insurance Information Sheet

Patient Name: _____ Date of Birth: _____
Assigned C.R.C. Doctor:_____ Todays Date:_____

Primary Insurance

Primary Insurance Name: _____

Member ID#:_____

Group Number:_____

Policy Holder Name:_____ Policy Holder Date of Birth:_____

Dependents Name if different from Policy Holder:_____

Secondary Insurance

Primary Insurance Name: _____

Member ID#:_____

Group Number:_____

Policy Holder Name:_____ Policy Holder Date of Birth:_____

Dependents Name if different from Policy Holder:_____

Evaluation and Management History Information Form

Date: ____/_____/_____First Name: _____ Last Name: _____ Date of Birth: ____/_____/_____

Reason for Visit: _____

Date of Last Physical: _____Physical Performed by: _____

History of Present Illness (PLEASE CHECK **"YES OR NO"** TO ALL OF THE FOLLOWING QUESTIONS)

Yes No

☐ ☐…… Do you have anal pain? How long have you had the pain? _____

☐ ☐…… Is the pain constant? How often? _____

☐ ☐…… Pain after a bowel movement? How long does the pain last? _____

☐ ☐…… Pain during a bowel movement? How long does the pain last? _____

☐ ☐…… Are you bleeding from the rectum? Bright Red?_____ Dark Red?_____ Black?_____

☐ ☐…… Do you feel rectal protrusion?

☐ ☐…… Do you feel rectal swelling?

☐ ☐…… Do you have itching in the rectum?

☐ ☐…… Do you have burning in the rectum?

☐ ☐…… Do you have rectal discharge?

☐ ☐…… Do you have rectal fullness?

☐ ☐…… Do you have mucous in your bowel movement?

☐ ☐…… Have you applied medications to the anal area? What medication? _____

☐ ☐…… Do you have the inability to hold: _____ solid stool _____ liquid stool _____ gas

☐ ☐…… Do you have soilage? How often? _____

☐ ☐…… Have you noticed change in bowel habits?

☐ ☐…… Are you constipated?

☐ ☐…… Do you require enemas? How often? _____

☐ ☐…… Do you require laxatives? How often? _____

☐ ☐…… Do you have abdominal pain? Where is the pain located? _____

☐ ☐…… Have you recently lost weight? How much? _____ Since (date) _____

How many bowel movements per week do you have? _____

List all Current physicians (Medical, Cardiologist, Nephrologist, or Hematologist, if applicable)	
Name of M.D. and Practice	Office Contact Information

Do you have a history of MRSA? ……..……☐Yes ☐No ☐Unknown

Do you have a **PACEMAKER**? ……☐Yes ☐No

Do you have a **DEFIBRILLATOR**? ……..…☐Yes ☐No ***If you have a defibrillator, please present a D.N.R. or Living Will.**

****If you have a Defibrillator/Pacemaker. Please present your Wallet Identification card. We will need to keep a copy on file.**

Do you have any body piercings/jewelry?.... ☐Yes ☐No ***If you have body piercings/jewelry please remove them prior to having ANY procedures.**

Preferred Laboratory Center_____

List all Surgeries	List all Medical Problems

Patient Name_____ **DOB**_____

HAVE YOU HAD THE FOLLOWING TESTS? IF SO, PLEASE PROVIDE TEST DATE.

Chest X-Ray_____ Kidney IVP_____ EKG _____ Colonoscopy_____

Barium Enema_____ Upper GI_____ Sigmoidoscopy_____ Other_____

Social History – Patient

Yes Formerly Never

☐ ☐ ☐ …….Do you smoke? If yes, average daily amount: _____

☐ ☐ ☐ …….Do you drink alcohol? If yes, average daily amount: _____

☐ ☐ ☐ …….Do you drink coffee or tea? If yes, average daily amount: _____

Sexual Preference: Heterosexual ☐ Homosexual ☐ Bisexual ☐

Travel Abroad Recently? Yes☐ No☐ If so, where? _____

Please List ALL Current Prescription Medications or Over the Counter Medications and Dosages

Medication Name	Dose Per Day	Medication Name	Dose Per Day

Are you currently taking blood thinners (Coumadin, etc.?) Yes☐ No☐ How often? _____

Are you currently taking Aspirin? Yes☐ No☐ How often? _____

Are you allergic to contrast dye (iodine, shellfish)? Yes☐ No☐

Are you allergic to any medications? Yes☐ No☐

If any allergies, describe the reaction that occurs: _____

FAMILY HISTORY

	Colon Polyps	Colon Cancer	Inflammatory Bowel Disease	Crohn's Disease	Ulcerative Colitis	Other cancers (Ovarian, gastric, kidney/urinary tract, gallbladder, central nervous system)
Yourself	☐	☐	☐	☐	☐	
Mother	☐	☐	☐	☐	☐	
Father	☐	☐	☐	☐	☐	
Sister(s)	☐	☐	☐	☐	☐	
Brother(s)	☐	☐	☐	☐	☐	

Please Indicate **Father** or **Mothers** side:

	Colon Polyps	Colon Cancer	Inflammatory Bowel Disease	Crohn's Disease	Ulcerative Colitis	Other cancers (ovarian, gastric, kidney/urinary tract, gallbladder, central nervous system, etc.)
Grandmother	☐F ☐M	☐F ☐M	☐F ☐M	☐F ☐M	☐F ☐M	
Grandfather	☐F ☐M	☐F ☐M	☐F ☐M	☐F ☐M	☐F ☐M	
Aunt(s)	☐F ☐M	☐F ☐M	☐F ☐M	☐F ☐M	☐F ☐M	
Uncle(s)	☐F ☐M	☐F ☐M	☐F ☐M	☐F ☐M	☐F ☐M	

REVIEW OF SYSTEMS

PLEASE CHECK EACH ITEM THAT RELATES TO YOUR HEALTH

Patient Name _____

Patient Date of Birth_____

CONSTITUTIONAL

☐ Weight Loss ☐ Fatigue ☐ Fever ☐ Chills

EYES

☐ Glasses/Contacts ☐ Pain ☐ Double Vision
☐ Glaucoma ☐ Cataracts

EAR, NOSE, THROAT

☐ Ringing in ears ☐ Vertigo ☐ Loss of hearing
☐ Sore throat ☐ Hoarseness ☐ Sinus pressure

CARDIOVASCULAR

☐ Chest pain ☐ Palpitations ☐ Hypertension
☐ Fainting spells ☐ Ankle swelling

RESPIRATORY

☐ Shortness of breath ☐ Coughing blood
☐ Wheezing ☐ Asthma

GASTROINTESTINAL

☐ Heartburn ☐ Nausea ☐ Vomiting
☐ Difficulty swallowing ☐ Jaundice

GENITOURINARY

☐ Pain urinating ☐ Burning ☐ Frequency
☐ Nighttime ☐ Blood in urine ☐ Difficulty urinating
☐ Abnormal discharge ☐ History sexually transmitted disease
FEMALE: ☐ Vaginal discharge # Pregnancies ____
Miscarriages_____ # Living children_____
Vaginal deliveries_____ # C-Sections_____
Last Pap Smear_____by Doctor_____

MUSCULOSKELETAL

☐ Arthritis

SKIN

☐ Rash/Sores ☐ Lesions ☐ Itching ☐ Burning

NEUROLOGICAL

☐ Seizures ☐ Weakness ☐ Paralysis
☐ Numbness ☐ Memory Loss

PSYCHIATRIC

☐ Sleep disturbances ☐ Anxiety ☐ Depression
☐ Mood swings

ENDOCRINE

☐ Loss of hair ☐ Heat/Cold intolerance ☐ Change in nails
☐ Diabetes ☐ Thyroid problems

HEMATOLOGIC

☐ Easy Bruising ☐ Easy Bleeding ☐ Enlarged Glands
☐ Excessive bleeding

ALLERGIC/IMMUNOLOGIC

☐ Hay fever ☐ Hives/Eczema ☐ HIV+ ☐ AIDS

PHYSICIANS NOTES ON POSITIVE FINDINGS

Patient Signature_____

Physician Signature_____

Colon & Rectal Clinic of Orlando

Consent and Acknowledgement Agreement

A. **Consent for Treatment**: I give consent to my physician, other attending physicians, and their assistants and designees, to provide me with such medical, surgical, diagnostic, or other treatment services judged necessary and/or appropriate. This consent includes my consent for diagnostic procedures such as anoscopy, flexible sigmoidoscopy, and all medical treatment rendered at my physician's office under his/her instruction; including X-Ray, laboratory procedures, and other tests, treatments, or medication, monitoring, and all other procedures or treatments that do not require my specific informed consent. I understand that in the course of treatment and diagnosis, cells, tissues, and/or parts may be removed from my body. I authorize my physician and his/her personnel to send the specimen to the lab of his choice when necessary in obtaining a diagnosis and authorize him/her and his personnel to dispose of any non-concerning cells, tissues, and/or parts that are not removed. Audio and/or video recordings are not allowed.

B. **General Acknowledgements**: I understand that the practice of medicine and surgery is not an exact science. I understand that medical and surgical treatment and diagnosis may involve risks of injury or even death. No guarantees have been made to me with respect to the results of my examinations or treatments. I understand that it is my responsibility to follow instructions and make arrangements for follow-up care as directed by my physician. I understand that I may review and obtain a copy of my medical record, at my own expense, and that this review shall take place during regular business hours.

C. **Assignment and Agreement to Pay**: I understand that I am responsible for payment of the services I receive and guarantee payment for these services. I hereby assign to the physicians, for application to bill for my services, all of my rights and claims for reimbursement under any federal or state healthcare plan (including but not limited to Medicare and Medicaid), insurance policy, any management care arrangement or other similar third party payer arrangement that covers healthcare costs and for which payment may be available to cover the costs of services provided to me. I understand that I am responsible for any applicable co-payment, deducible, co-insurance, and/or non-covered costs and charges. I understand that not all insurance companies pay the usual and customary fees of physicians and/or professionals associated with an office practice. Therefore, when permitted by law, any outstanding balance will be my responsibility. I understand and agree that I am responsible for the cost of collection and/or reasonable attorney fees related to my account. I understand that my health information will be released to my insurers, payers, or others for billing purposes. In addition, I understand that I may receive separate bills from other independent physicians involved in my care, including radiologists, anesthesiologists, pathologists, emergency room physicians. **Medicare/Medicaid:** I certify that the information given to me in applying for payment under Title XVII/XIX of the Social Security Act is correct. I authorize any medical or other information needed in determining a claim for payment for treatment and/or diagnosis to be release to Social Security Administration/Division of Family Services, its intermediaries, or carriers. I certify that all insurance payments pertaining to treatment and/or diagnosis may be assigned to the physician treating me.

D. **Insurance Acknowledgements & Pre-Certification**: I acknowledge that it is my responsibility to understand my benefits of my insurance plan and its requirements when seeking treatment and/or care not provided by my primary care provider. I understand that it is my responsibility to contact my insurance company to determine if a pre-certification/prior authorization is needed for an upcoming procedure or service. I understand that if a pre-certification/prior authorization is required, it is my responsibility to notify the office prior to the procedure date.

E. **Photograph Authorization**: In connection with the medical services in which I am receiving, I consent that photographs may be taken in connection to my medical treatment. These photographs may be used for medical records only, unless in judgment of my physician, medical research of education will benefit by their use. In that event, I agree they may be used for the purposes provided and that my identity is not revealed by the photographs or by descriptive texts.

F. **Release of Information**: I authorize any physician examining and/or treating me to release to any third party (such as an insurance company or government agency) and any medical information and records concerning diagnosis and treatment when requested for use in determining claim for payment.

_____ _____ _____

Signature of Patient/Authorized Representative | Date | Patients Date of Birth

_____ _____

Printed Name of Patient/Authorized Representative | Relationship of Authorized Representative (if applicable)

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RE: Financial Responsibility Notice

Your physician has scheduled you for a procedure/surgery, the following will help to explain your financial responsibilities.

Underwood Surgery Center – You will receive a bill from anesthesia, Underwood Surgery Center (facility) and your physician. We will provide you with an estimated charge, insurance payment and your balance.

Outpatient Surgery – You will receive a bill from anesthesia, the facility and your physician. We will provide you with an estimate for the physician portion after insurance coverage.

In-patient Hospital – The facility will contact you in regard to the billing and your responsibility. We will contact you with the physician portion of the bill, insurance estimate of payment and an estimate of the patient balance.

In addition, you may receive a bill for pathology if your physician sent specimens for analysis.

Our Patient Financial Representative will contact you prior to the date of your scheduled procedure/surgery and provide you with an estimated patient responsibility. You will need to make payment no later than **3 days prior to your appointment date.** You may contact the Patient Financial Representative by calling: 407.422.3790 EXT 3022.

I have been given the patient responsibility notice and understand that I will be contacted regarding my financial obligation prior to the date of my procedure/surgery.

_____	_____	_____
Patient Signature	Date Signed	CRC Employee Witness
_____	_____	_____
Print Name	Patients Date of Birth	Account Number

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I hereby authorize use or disclosure of protected health information about me as described below.

RECORDS ON (PATIENT NAME) _____(DOB) _____

The following specific person or class of persons or facility is authorized to make the requested use or disclosure. If you are sending records to the Colon & Rectal Clinic of Orlando, please put the doctor's name who has your records here:

RECORDS SENT FROM: _____

_____

_____

The following person or class of persons may receive disclosure of protected health information about me. If you are sending records to the Colon & Rectal Clinic of Orlando, please put the doctor's name you are seeing at CRC here:

RECORDS SENT TO: _____

_____

_____

WE WILL ONLY SEND RECORDS TO ONE PHYSICIAN FREE OF CHARGE – WE WILL GIVE YOU A COPY OF YOUR RECORDS TO SEND IT TO MORE PHYSICIANS IF NECESSARY.

Specific description of information to be released (must include date(s) of service):

_____

The information to be released will be used for the purpose described below:

_____

I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
I may revoke or withdraw this authorization by notifying COLON & RECTAL CLINIC OF ORLANDO in writing of my desire to revoke it. However, I understand that any action already taken in advance of this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.
The authorization will expire on _____, or 1 (one) year after the date of said authorization.

_____	_____	_____
Signature of Individual ~~OR, if applicable~~	Date of Signature	Date of Birth or SS Number
_____	_____	_____
Signature of Guardian	Date of Signature	Description of Guardian's Personal Representative's Authority to Act for the Individual

A copy of this completed, signed and dated form must be given to the Individual or Person signing on the Individual's behalf.