COLON & RECTAL SURGERY ASSOCIATES

PATIENT INFORMATION

"PLEASE PRINT" and fill in ALL spaces

PATIENT NAME: _____ DATE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME#: ( ) _____-_____ CELL#: ( ) _____-_____ BEST DAYTIME PH# ☐ HOME / ☐ CELL

E-MAIL ADDRESS: _____ (for patient portal)

DOB _____/_____/_____ AGE: ____ SEX: M / F SS#: _____ MARITAL STATUS: M S W D

PLACE OF EMPLOYMENT: _____ OCCUPATION: _____ WORK#_____

SPOUSE NAME: _____ CELL#: ( )_____ DOB: ____/_____/_____

REFERRING DR.: _____ PRIMARY DR. : _____

PHARMACY: _____ PH# or ADDRESS: _____

INSURANCE INFORMATION

IS INSURANCE IN PATIENTS NAME? YES / NO **IF NO, PLEASE LIST FOLLOW INFORMATION:**

PRIMARY CARDHOLDER'S NAME: _____ **EMPLOYER**: _____

SS#: _____-_____-_____ **DOB**: ____/_____/_____ **EMPLOYER PH#**: _____

HIPAA INFORMATION

List spouse, relatives (&/or) friends we may release your medical information to/whom may call on your behalf

Name: _____ Relation: _____ Phone: ( ) _____-_____

Name: _____ Relation: _____ Phone: ( ) _____-_____

_____ (READ & INITIAL) IT IS OUR OFFICE POLICY THAT YOUR COPAY, DEDUCTIBLE &/OR CO-INSURANCE BE PAID AT EACH OFFICE VISIT. IF SURGERY/PROCEDURE IS SCHEDULED WE REQUEST ANY DEDUCTIBLE &/OR COINSURANCE BE PAID BEFORE THE SURGERY/PROCEDURE. YOU ARE ALSO RESPONSIBLE FOR ANY BALANCES NOT PAID/COVERED BY YOUR INSURANCE COMPANY.

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance and any other health plans to:

SEAN MAYFIELD, M.D., JENNIFER SILINSKY, M.D., MATTHEW ZELHART, M.D.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered valid as an original. I hereby authorize said assignee to release all information necessary to secure this payment.

_____ _____

SIGNATURE OF PATIENT OR LEAGAL GAURDIAN DATE

COLON AND RECTAL SURGERY ASSOCIATES

HISTORY AND PHYSICAL

Name: _____ Age_____ Sex: M F

Reason for visit: _____ HT_____ WT:_____

Referred by: _____ Primary is Dr. _____

I also see Dr. _____ Dr _____

Occupation: _____ Place of employment: _____

Medications: (separate list if necessary)

1.) _____mg_____times/day 4.) _____ mg_____times/day
2.) _____mg_____times/day 5.) _____ mg_____times/day
3.) _____mg_____times/day 6.) _____ mg_____times/day

Medication Allergies & Reaction: _____

_____

Colon exam: Last colonoscopy:(year) _____ performed by _____Barium enema:(year)_____

If having colonoscopy specify type: Screening (preventive)_____ Diagnostic (previous polyps, etc.) _____

Family History: (blood relation) **Colon Cancer** _____ **Colon Polyps** _____

Breast Cancer: _____ **Uterine or Ovarian Cancer:** _____ **Other serious ailments:** _____

Past Surgeries: (with approx. date) _____

_____ _____ _____

_____ _____ _____

Social history: **At home I live.... alone / with** _____

Tobacco: No__ Yes ___/ ____ packs per day. **Alcohol:** No___ Yes ___/ _____drinks/beers per week.

REVIEW OF SYSTEMS: CHECK ALL THAT APPLY

Gastrointestinal
- ⊏ Bleeding with BMs
- ⊏ Constipation
- ⊏ Change in bowel habits
- ⊏ Diarrhea
- ⊏ Rectal pain
- ⊏ Soiling/ Incontinence
- ⊏ Heartburn
- ⊏ Abdominal pain
- ⊏ _____

Skin
- ⊏ Bruise easily
- ⊏ Rashes

Endocrine
- ⊏ Diabetes
- ⊏ Hypo/hyperthyroid
- ⊏ Steroid use

General
- ⊏ Fevers
- ⊏ Chills
- ⊏ Sweats
- ⊏ Weight loss
- ⊏ Bleeding history
- ⊏ Immune Deficiency

Urinary
- ⊏ Painful Urination
- ⊏ Blood in Urine
- ⊏ Air in Urine
- ⊏ Recurrent Infections
- ⊏ Incontinence
- ⊏ Dialysis

Muscle/Joint
- ⊏ Arthritis
- ⊏ Weakness in _____

Respiratory
- ⊏ Asthma
- ⊏ Bronchitis
- ⊏ Shortness of breath
- ⊏ Productive cough

Cardiovascular
- ⊏ High Blood Pressure
- ⊏ Heart Attack
- ⊏ Irregular Heart Beat
- ⊏ Rapid Heart Beat
- ⊏ Mitral Valve Prolapse
- ⊏ Valve Disease
- ⊏ Leg Swelling

Neurological
- ⊏ Permanent stroke
- ⊏ Transient stroke
- ⊏ Seizures

Cancer Treatment
- ⊏ Chemo ⊏ Radiation
(area treated & year)

_____

_____

Blood Disorders:
- ⊏ HIV/AIDS

Reproductive
(men only)
- ⊏ Erectile dysfunction

(women only)
- ⊏ Hysterectomy
- ⊏ Childbirth
children _____
- ⊏ Difficult delivery (tearing)
- ⊏ C-section: #_____
- ⊏ Still Menstruating

Other Medical Problems: _____

_____

_____ _____

PATIENT'S SIGNATURE DATE

Reviewed with patient and agree with above

DATE: _____ _____

Physician Signature

⊏ S. MAYFIELD, MD ⊏ J. SILINSKY, MD
⊏ M. ZELHART, MD

COLON & RECTAL SURGERY ASSOCIATES
PAYMENT POLICY

OFFICE VISITS:

We will be happy to file your claim with your insurance company but we do require payment of all **CO-PAYS, DEDUCTIBLES AND CO-INSURANCE PERCENTAGES BE MADE ON THE DATE OF SERVICE.**

PROCEDURES PERFORMED IN OFFICE:

SOME PROCEDURES PERFORMED IN THE OFFICE ARE NOT COVERED BY YOUR CO-PAY. YOUR insurance company may consider them to be a medical procedure and pay under your medical plan with deductible and percentage being applied. These possibilities and most common are: **EXAM WITH ANOSCOPY OR PROCTOSCOPY, EXCISIONS, DRAINAGES, BANDING OF HEMORRHOIDS, etc.**

FOR COLONOSCOPIES:

PLEASE CALL YOUR INSURANCE COMPANY AND FIND OUT HOW THEY COVER THE TYPE OF SCOPE YOU WILL BE HAVING. Insurance companies pay differently depending on the diagnosis. ASK HOW THEY PAY WHEN HAVING A **"SCREENING"** (preventative) or **"DIAGNOSTIC"** (previous polyps,etc). We need to know how they cover and you need to state the type on your history and physical form.

SURGERY, PROCEDURE OR COLONSCOPY:

We will, **when scheduled**, verify your coverage. The amount that **IS NOT COVERED** by your insurance and therefore due **FROM YOU, THE PATIENT**, will be required to be paid **IN-FULL BEFORE** the date of procedure. Someone from our office will call you **a few days prior to surgery** to let you know the amount, if any, due from you.

I, _____ have read and agree to the terms above.
PRINT PATIENT NAME

_____ Date: _____
PATIENT SIGNATURE

In office Procedure Informed Consent

Patient Name _____ **D.O.B.** _____

IMPORTANT INFORMATION ABOUT THIS DOCUMENT READ CAREFULLY BEFORE SIGNING

To the Patient: You have been told that you should consider medical treatment / surgery. Louisiana law requires us to tell you (1) the nature of your condition, (2) the general nature of the medical treatment / surgery, (3) the risks of the proposed treatment/surgery, as defined by the Louisiana Medical Disclosure Panel or as determined by your doctor, and (4) reasonable therapeutic alternative and material risks associated with such alternatives.

You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved.

In keeping with the Louisiana law of informed consent, you are being asked to sign a confirmation that we have discussed all these matters. We have already discussed with you the common problems and risks. We wish to inform you as completely as possible. Please read the form carefully. Ask about anything you do not understand, and we will be pleased to explain it.

Possible In Office Procedures, such as: Ligation of Hemorrhoid(s), Incision and Drainage of an Abscess, Excision of a Thrombose Hemorrhoid, Excision of an Anal Tag, Fulguration and/or chemical cauterization of wound, granulation tissue, condyloma, etc. or Anal Biopsy.

1. MATERIAL RISKS OF TREATMENT / PROCEDURE:
   (a) All medical or surgical treatment involves risks. Listed below are those risks associated with this procedure that we believe a reasonable person in your (the patient's) position would likely consider significant when deciding whether to have or forego the proposed therapy. Please ask your physician if you would like additional information regarding the nature or consequences of these risks, their likelihood of occurrence, or if there are other associated risks that you might consider significant but may not be listed below. The risks as determined by the Louisiana Medical Disclosure Panel are: Bleeding at operative site and post-procedure pain.

   (b) Risks generally associated with any surgical treatment / procedure, including local are: infection, bleeding and pain.

Reasonable therapeutic alternative, the risks associated with such alternatives and risk of treatment is are: possible infection or continuation of symptoms.

By signing this informed consent, you consent to an in-office procedure as described above.

_____ _____

Patient Signature (Authorized representative, if minor) **Date**

Colon & Rectal Surgery Associates Patient Code of Conduct

Due to recent events in our region, we have composed this Code of Conduct with the hope that it will encourage and provide a safe and healthy environment for physicians, staff, visitors, patients, and their families. Colon & Rectal Surgery Associates expects visitors, patients, and accompanying family members to refrain from unacceptable behaviors that are disruptive or pose a threat to the rights or safety of physicians, patients, and staff.

The following behaviors are prohibited:

• Possessing firearms or any weapon

• Intimidating or harassing staff or other patients

• Making threats of violence through phone calls, letters, voicemail, email, or other forms of written, verbal, or electronic communication

• Physically assaulting or threatening to inflict bodily harm

• Making verbal threats to harm another individual or destroy property

• Damaging business equipment or property

• Making menacing or derogatory gestures

• Making racial or cultural slurs or other derogatory remarks

If you are subjected to any of these behaviors or witness inappropriate behavior, please report to any staff member. Violators are subject to removal from the facility and/or discharge from our practice.

As a patient visiting our practice, please consider the following:

- Please communicate all issues that you wish to discuss with the doctor at the time of your appointment. Due to the delicate nature of our specialty, most questions not asked while in the office may require another visit so that the doctor can provide the answers you may need and the quality of care you deserve.
- Our practice follows a zero-tolerance policy for aggressive behavior directed by patients against our physicians and/or staff.
- Please be courteous with the use of your cell phone and other electronic devices. When interacting with any of our staff, please put your devices away. Set the ringer to vibrate before storing it away and entering our exam rooms.
- Our available appointment time is very important, as such we will charge a $50 no show fee for missed appointments and after 3 no show appointments, you will be discharged from our practice.
- Outstanding balances owed to our office will be forwarded to a collection agency, if no arrangements are made with our office, within 90 days of delinquency.
- If you have any questions about the care or are unhappy with the service received in our office, please contact our practice manager before you leave our office so that any clarifications about your care or the services you received can be addressed.

By signing this document, you agree to abide by this Patient Code of Conduct.

Print Patient Name_____ Date _____

Patient Signature _____ Relationship to Patient _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

SEAN MAYFIELD, M.D. JENNIFER SILINSKY, M.D. MATTHEW ZELHART, M.D.

Notice to our Patients:

We are required to provide you with a copy of our Notice of Privacy Practices upon request, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign the acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____

Please print your name here

_____

Signature

_____

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement.
- ☐ We weren't able to communicate with the patient.
- ☐ Other (Please provide specific details)

_____

_____

_____

_____ _____

Employee signature *Date*