

**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 PATIENT'S 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.

**\*\*\*THIS OFFICE DOES NOT ACCEPT MEDICAID PRIMARY\*\*\***

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.,**

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 LEGAL GAURDIAN

\_\_\_\_\_  
DATE

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

SEAN MAYFIELD, M.D. JENNIFER SILINSKY, 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*

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

# 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 COLONOSCOPY:

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

\_\_\_\_\_  
PATIENT SIGNATURE

Date: \_\_\_\_\_

## 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.**

#### I. 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/Office Policies

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.

### **Office policies you should be aware of:**

- Appointments are given a 15-minute grace period for arrival. If you arrive more than 15 minutes after your appointment, you will likely have to reschedule.
- Our office takes cash and credit cards as a form of payment. All credit cards are subject to a 3.5% service fee except for HSA cards.
- All our physicians are BOARD CERTIFIED COLORECTAL SURGEONS, and it is our policy that once you establish care with one of our physicians, you cannot switch to another physician in our practice. Established care means you've seen one of our physicians in the hospital, in the office or had a surgical procedure by one of the physicians.

### **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 and the policies of this office.

Print Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Patient Signature \_\_\_\_\_ Relationship to Patient \_\_\_\_\_