COLON & RECTAL SURGERY, INC.

Please complete attached paperwork and bring to your appointment with your insurance card, co-pay and photo ID. If a referral is required, please be sure to contact your insurance company or Primary Care Physician prior to your scheduled visit.

*If you need to cancel or reschedule your appointment, please call the office at 614-759-5060 during regular business hours.

Office Locations

East Office:
5965 East Broad St., Suite #250, Columbus, OH 43213
(Medical Building on Mt. Carmel East Hospital Campus, Building #5)

West Office:
745 West State St., Suite #605, Columbus, OH 43222
(Park in Garage #1 right off of Town Street, located behind the School of Nursing)

Circleville Office:
600 N. Pickaway St., Suite #204, Circleville, OH 43113 (Berger Hospital)

Patient Registration

Date: _____

Patient's Name: _____
Last First Middle

Address: _____
Street City State Zip

Social Security #: _____-_____-_____ Birth Date: _____ Age: _____ Marital Status: _____ Sex: ☐F ☐M

Height: _____ Weight: _____ Race/Ethnicity: _____ E-mail Address: _____

Home Phone: (_____)_____ Mobile Phone: (_____)_____ Driver License# : _____

Occupation: _____ Employer: _____ Work Phone: (_____)_____

Spouse's Name: _____ Spouse's Social Security #: _____- _____- _____ Birth Date: _____

Employer: _____ Work Phone: (____)_____ Mobile Phone: (____)_____

Emergency Contact: **(Other Than Spouse)**

Name: _____ Relation to Patient: _____

Home Phone: (_____)_____ Is this contact for emergency purposes only? ☐Yes ☐No

May we call you at: Home? ☐Yes ☐No **Work**? ☐Yes ☐No **Mobile?** ☐Yes ☐No

May we leave a message at: Home? ☐Yes ☐No **Work?** ☐Yes ☐No **Mobile?** ☐Yes ☐No

May we leave message with family member or others? ☐Yes ☐No **Name:** _____

Primary Care Physician: _____ **Telephone:** (_____)_____

Referring Physician: _____ **Telephone:** (_____)_____

Insurance Information

Primary Insurance Coverage:

Insurance Co. _____ Insured: _____

Address _____ Member ID/ Subscriber #: _____Group #: _____

Telephone: (_____)_____ Relationship to Patient: ☐self ☐spouse ☐child

Secondary Insurance Coverage:

Insurance Co. _____ Insured: _____

Address: _____ Member ID/ Subscriber #: _____ Group #: _____

Telephone: (_____)_____ Relationship to Patient : ☐self ☐spouse ☐child

ASSIGNMENT OF BENEFITS: 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: Colon & Rectal Surgery, Inc.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges for services or collection fees, including the balance remaining after payment of possible insurance benefits. I understand that if I have an insurance plan that requires a referral to see a specialist, and I do not obtain the required referral, that I will be responsible for all charges. I hereby authorize said assignee to release all information necessary to secure the payment.

Signed: _____ **Date**: _____

Patient History

What is your primary problem? How Long?_____

Please indicate if you are having any of the following:

	Yes	No	Have you had a Colonoscopy?		
Rectal Pain			When?		
Rectal Bleeding			Do you have a Pace Maker?		
Itching/Burning			Do you have a Defibrillator?		
Protrusion/Swelling			Do you have Sleep Apnea?		
Discharge			C-PAP Setting?		
Abdominal Pain			How often do you move bowels?		
Constipation			Do you take antibiotics before procedures?		
Nausea			Have you ever been pregnant?		
Diarrhea			How many Pregnancies?		
Blood in Stool			Vaginal or C-Section?		
Change in Bowel Habits			**Social History**	**Yes**	**No**	**Amount**
Fecal Incontinence			Tobacco?			
Diverticulitis			Alcohol?			
Vomiting			Illicit Drugs?			

Please list Surgical History/ Operations:

_____

Medical History	Patient	Family	Review of Symptoms		Yes	No
Colon Polyps			**Lymph:**	Swollen Glands?		
Colon Cancer				Fatigue?		
Crohn's Disease			**Hematologic:**	Easy Bruising?		
Ulcerative Colitis			**General:**	Weight Loss?		
Breast/Ovarian Cancer			**Skin:**	Rashes?		
Prostate Cancer			**Neurological:**	Dizziness?		
Heart Disease				Light-headed?		
Sickle Cell Disease			**Eyes:**	Vision Changes?		
Thyroid Disease			**Cardiac:**	Chest Pain?		
Lung Disease				Pressure/ Tightness?		
Liver Disease				Palpitations?		
Kidney Disease			**Respiratory:**	Shortness of Breath?		
Ulcers				Coughing?		
High Cholesterol				Wheezing?		
Stroke			**Urinary Tract:**	Burning w/ Urination?		
Diabetes				Frequent Urination?		
High Blood Pressure				Inability to Urinate?		
TB			**Musculoskeletal:**	Leg or joint Swelling?		
HIV +			**Psych:**	Mood Changes?		

Privacy Policy for Colon & Rectal Surgery, Inc.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION AS REQUIRED BY LAW. PLEASE REVIEW IT CAREFULLY.

This is a formal notification, as required by the government concerning the privacy of this practice

Colon & Rectal Surgery Inc. believes that maintaining the confidentiality of all patient health information is crucial. We pledge that Colon & Rectal Surgery, Inc. will not release your personal information to anyone without your consent. You may designate whom you wish your information to be released by completing the Authorization for Use and/or Disclosure of Protected Health Information (PHI) available in the office. Individually identifiable health information is information that is a subset of health information, including demographic information collected from our patients, whether oral or recorded, or written, created by a health care provider. Colon & Rectal Surgery, Inc. will use a standard of "minimum necessary" when using or disclosing your protected health information. (Minimum necessary does not apply to requests for health care provider treatment or otherwise as required by law.)

Permitted uses and disclosures for the purpose of activities involving the use or disclosure of an individual's identifiable health information includes:

• To you, the individual;
• For treatment, payment, or health care operations; this includes coordination with other physicians involved in your care, referrals, scheduling tests, related care needs such as home care agencies, Hospice, or spiritual support needed by you during your course of care.
• Appointment reminders, phone calls at home & work, on answering machines, appointment cards and health related benefit services only with your consent identified on the registration form.
• For the purpose of research.
• Pursuant to your authorization;
• Consent is not required for emergency care and treatment. An emergency is identified as a medical condition that in the judgment of the physician requires information for care on your behalf.

Disclosures can be made without your consent, which are:

• Disclosure required by the government or law enforcement agencies, including transplant registries.
• Information used for public health purposes, medical examiners or related to a person's death, for disease tracking, and funeral director.
• Information used for health care oversight, as needed for a site review by an insurance Program.
• Worker's compensation or employee paid exams.

Your rights:

• You may request restrictions on certain uses and disclosures of your protected health information.
• You have the right to receive confidential communications of your protected health information.
• You have the right to inspect, amend and have copies of your protected health information, but there may be a fee for copying and postage. This is currently $30.
• You have the right to receive all accounting of disclosures of your protected health information.
• You have the right to receive a notice electronically, if feasible.

We reserve the right to change the terms of our Privacy Policy. We will notify you within sixty (60) days of any changes to our Privacy Policy. The changes will be effective retroactively to the initial date of the Privacy Notice. You may change the status of your consent or revoke at any time in writing. To revoke your consent, make changes, please contact our Compliance Officer. If you feel we are not complying with the requirements, you may also file a written complaint with the Secretary of the U. S. Department of Health and Human Services Office for Civil Rights or the Ohio Medicare Carrier, GBA Palmetto.

Office of Civil Rights Department of Health & Human Services
233 N. Michigan Avenue, Suite 24
Chicago, IL 60601

Patient Name: (Printed) _____ DOB _____

Patient Signature upon receipt: _____ DATE: _____

Patient unable to sign due to: _____ DATE: _____

Refused to sign: _____ DATE: _____

Colon & Rectal Surgery, Inc.

Consent For The Use And/Or Disclosure of Protected Health Information For the Purpose of Treatment, Payment and Healthcare Operations

I (Print Name),_____ ,understand that as part of my hea1thcare, Colon& Rectal Surgery, Inc. creates and maintains records of my protected health information for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare treatment or to conduct healthcare operations. I hereby consent to treatment by Colon & Rectal Surgery, Inc., and to use and/or disclosure of my protected health information for the purpose of treatment, payment, and healthcare operations.

I understand that my protected health information includes any information about my health that has been created or received by Colon & Rectal Surgery, Inc., my physician, another health care provider, my health insurance plan, my employer, or a healthcare clearinghouse and may include health information related to my past, present, and future physical and mental health or condition and that this health information identifies me or may be used to identify me.

I understand that I must sign this form or Colon & Rectal Surgery, Inc. may refuse to provide healthcare services to me. I also understand that Colon & Rectal Surgery, Inc.'s treatment practices may include sending postcard reminders, leaving messages on answering machines, phone calls at home or at work, referral letters to physicians and notices regarding my continuing healthcare and that my name may be included in a directory for internal use by Colon & Rectal Surgery, Inc.

I understand that Colon & Rectal Surgery, Inc. may use my healthcare information for the purposes of research.

I have been provided a copy and understand that I have the right to read and review Colon & Rectal Surgery, Inc.'s ***Notice of Privacy Practices*** before signing this consent form. Colon & Rectal Surgery, Inc.'s ***Notice of Privacy Practices*** provide a more complete description of the uses and disclosures of my protected health information. I understand that Colon & Rectal Surgery, Inc. may change the practices described it its ***Notice of Privacy Practices***. I understand that Colon & Rectal Surgery, Inc.'s ***Notice of Privacy Practices*** will be posted in the office and that I may receive a copy of the ***Notice of Privacy Practices***, if I ask for one.

I understand and acknowledge that I have the right to request that Colon & Rectal Surgery, Inc. restrict how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations. I understand that Colon & Rectal Surgery, Inc. is not required to agree to the restrictions that I request, but if it does agree to my requested restrictions then Colon & Rectal Surgery,inc. is bound by those restrictions. I request the following restriction(s) to the use or disclosure of my protected health information:

_____

_____

Colon & Rectal Surgery, Inc. hereby: ☐ Accepts ☐ Denies this requested restriction.

_____ _____

COLON & RECTAL SURGERY, INC. REPRESENTATIVE DATE

I understand and acknowledge that I have the right to revoke this consent, in writing, at any time, except to the extent that Colon & Rectal Surgery, Inc. has already taken action in reliance upon it.

_____ _____

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE DATE

_____ _____ _____

RELATIONSHIP TO PATIENT WITNESS DATE

MEDICATION FLOW SHEET

PATIENT NAME: _____ DOB: _____ TODAY'S DATE: _____

FAMILY DOCTOR: _____ DO YOU SMOKE? **Yes /No** FORMERLY? **Yes/ No**

****PHARMACY:** _____**PHONE #:** _____

MEDICATION ALLERGIES	TYPE OF REACTION

DATE STARTED	MEDICATIONS	DOSAGE	WHEN TAKEN
Example: 01/01/00	*Aspirin*	*80 mg*	*One tablet daily*

For Office Use Only:

VITALS: HT: _____ WT: _____ BP: _____ BMI: _____ PULSE:_____