Winter Park Colon & Rectal Specialists, LLC

JACQUELINE L. KAISER, MD
255 N. Lakemont Ave #100
Winter Park, FL 32792

DATE: _____

PLEASE PRINT

NAME: _____ **GENDER:** ❑M ❑F
Last First MI

DATE OF BIRTH: _____ **AGE:** _____ **SSN:** _____

MARITAL STATUS: ❑Single ❑Married ❑Widowed ❑Divorced ❑Separated

RACE: ❑White ❑Black or African American ❑American Indian or Alaska Native ❑Asian

❑Hawaiian or Other Pacific Islander

ETHNICITY: ❑Hispanic/Latino Or ❑Not Hispanic/Latino ❑ Decline to answer

PREFERRED LANGUAGE: ❑ English **OR** _____

Preferred Phone #: Please check one of the boxes below ↓

ADDRESS: _____ **HOME PH:** _____ ☐
Street

_____ **CELL PH:** _____ ☐
City State Zip

EMAIL: _____ **WORK PH:** _____ ☐

EMPLOYER:_____**OCCUPATION:** _____

With whom may we discuss or release your medical information:

_____

Emergency Contact:_____ **PH#:** _____ **Relationship:** _____

Primary Care Physician (PCP)_____

***PHARMACY NAME, PH# and/or ADDR:** _____

Primary Insurance:

INSURANCE CO: _____

SUBSCRIBER'S NAME (IF DIFFERENT):

_____
Last First MI

SUBSCRIBER'S DOB:_____

RELATION TO PATIENT: _____

Secondary Insurance:

INSURANCE CO: _____

SUBSCRIBER'S NAME (IF DIFFERENT):

_____
Last First MI

SUBSCRIBER'S DOB: _____

RELATION TO PATIENT: _____

Winter Park Colon & Rectal Specialists, LLC

JACQUELINE L. KAISER, MD

255 N. Lakemont Ave. #100
Winter Park, FL 32792

DATE: _____

PATIENT NAME: _____ **DOB:** _____

REASON FOR THIS VISIT: _____

REFERRED BY: ❑Dr._____ ❑Patient_____

❑Hospital _____ ❑Insurance ❑Internet

CURRENT MEDICATIONS & SUPPLEMENTS

_____

_____

_____

_____

_____

_____

_____

Do you take Aspirin? Yes ❑ No ❑

ALLERGIES TO MEDS, LATEX, ADHESIVE, ETC.

_____

_____

_____

_____

RECENT HOSPITALIZATIONS

REASON **DATE**

_____

_____

_____

_____

PLEASE ANSWER THE FOLLOWING REGARDING YOUR CONDITION:

Do you have bleeding from the rectum? Yes❑ No❑

Do you have anal or rectal pain? Yes❑ No❑

Do you have pain with bowel movements? Yes❑ No❑

Do you have abdominal pain? Yes❑ No❑

Do you have high blood pressure? Yes❑ No❑

Do you have diabetes? Yes❑ No❑

Have you lost weight recently? Yes❑ No❑

If yes, how much? _____

Have you traveled out of the country recently? Yes❑ No❑

If yes, where?_____

Smoking Status/History

- ❑ Never Smoked
- ❑ Former Smoker
- ❑ Current some day smoker
- ❑ Current every day smoker

Do you drink alcohol? Yes❑ No❑

If yes, how much? ____per day ____per wk

FEMALES ONLY

Number of pregnancies: _____

# of Vaginal deliveries: _____

# of Cesarean sections: _____

Winter Park Colon & Rectal Specialists, LLC
Jacqueline L. Kaiser, MD

Thank you for choosing Dr. Kaiser as your health care provider. We are committed to the success of your treatment and believe that in the interested of an on-going, mutually satisfying doctor-patient relationship it is important to clearly state the terms of our service. Therefore, we request that you read and sign the following Release of Medical Information and Financial Policy prior to treatment. Minors must be authorized by the signature of a parent or guardian.

RELEASE OF MEDICAL INFORMATION

Our Notice of Privacy Practices (available in our lobby) provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our Notice, this organization originates and maintains health records describing your health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care of treatment. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or healthcare operations. We are not required to agree to this restriction but if we do we are bound by our agreement. By signing this form, you are consenting to the use and disclosure of protected health information about you for treatment, payment and other health care operations. You have the right to revoke this consent, in writing, except to the extent that our organization has already taken action in reliance thereon.

FINANCIAL POLICY

We will file your insurance for you, however, it is your responsibility to verify your own insurance benefits and notify us of any changes. Ultimately, payment for services is the responsibility of the patient or guarantor.

PAYMENT, CO-PAYMENT, PERCENTAGES AND OR DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE. We accept cash, checks, Visa, Master Card, Discover and American Express.

PPO/MEDICARE: As a participating provider we are contractually required to collect co-payments, percentages and deductibles at the time of service. If your insurance company has not paid your account in full within 45 days you will be responsible for payment.

HMO: As a participating provider we are contractually required to collect co-payments, percentages and deductibles at the time of service. It is the patient's responsibility to ensure that Jacqueline L. Kaiser, MD and/or VitalMD is a participating provider in your health plan and to have a referral from your primary care physician prior to your appointment(s). Please check to make sure the referral includes an authorization number, number of visits approved and an expiration date. By contract we are unable to see you without this.

NON-COVERED SERVICES: Please be aware that some of the serviced provided may be considered by your insurance plan to be "non-covered" or "not medically necessary", therefore, you will be expected to pay for them at the time of service. *An **ANOSCOPY** may be performed as part of your examination. Some insurance plans consider this a surgical procedure and may charge this towards your deductible.*

NON-PARTICIPATING COMPANIES: Your insurance policy is a contract between you and your insurance company. Dr. Kaiser is not a party to that contract. You are responsible for payment in full for charges incurred at the time of service. We charge what is reasonable and customary for our area based on the Health Care Financing Administration. You can file a claim to your insurance company for reimbursement at their non-participating rate.

MISSED APPOINTMENTS: We realize your time is valuable and that long delays in the schedule are unacceptable so we do our best to schedule carefully. It is very important that you give us 24 hours notice when you are not able to make your appointment. We reserve the right to charge a $25 fee for any missed office appointments and an additional fee of $100 for any missed surgical appointments, including but not limited to colonoscopy, sigmoidoscopy and office surgical procedures.

OTHER FEES: We charge $30 for any check that is returned for nonsufficient funds. If your account is assigned to an outside collection agency you agree to reimburse us an additional fee of 30-50% of the debt and all expenses, including reasonable attorneys' fees, we incur in such collection efforts.

My signature below confirms my understanding and agreement to the above Release of Medical Information and Financial Policy.

Patient Signature **Date**

_____