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: ____________________

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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

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

Health History Questionnaire

Please fill this from out completely and bring it to your appointment.

Patient Name:______________________________________ **Date of Appointment:**_________________

Past Medical History (please check any medical problems you have or have had in the past):

Past	Present		Past	Present		Other (specify)
❑	❑	Anemia	❑	❑	GERD(Heartburn)	
❑	❑	Anxiety	❑	❑	Heart Disease or Heart Attack	
❑	❑	Arthritis	❑	❑	Hepatitis	____________________
❑	❑	Cancer - type ______________________	❑	❑	High Cholesterol	____________________
			❑	❑	Hypertension (high blood pressure)	____________________
❑	❑	Cataracts	❑	❑	Irritable Bowel Syndrome	____________________
❑	❑	Chronic Lung Disease	❑	❑	Kidney Disease	
❑	❑	Colon Polyps	❑	❑	Kidney Stones	
❑	❑	Congestive Heart Failure	❑	❑	Liver Disease	
❑	❑	Crohn's Disease	❑	❑	Osteoporosis	
❑	❑	Deep Vein Thrombosis	❑	❑	Pancreatitis	
❑	❑	Depression	❑	❑	Sleep Apnea	
❑	❑	Diabetes Mellitus	❑	❑	Thyroid Disease	
❑	❑	Fibromyalgia	❑	❑	Ulcerative Colitis	

Past Surgical History (Check any surgeries you have had *AND THE YEAR* of the surgery if you know it):

- ❑ Appendectomy
- ❑ Bowel Resection
- ❑ Breast Surgery - type:______________________
- ❑ Cholecystectomy (gall bladder removal)
- ❑ Colonoscopy - Year(s):_________________ Polyps? Yes❑ No❑
- ❑ Cosmetic Surgery
- ❑ C-section Delivery
- ❑ Eye Surgery
- ❑ Heart Surgery
- ❑ Hernia Repair
- ❑ Hysterectomy
  - ❑ ovaries removed?
- ❑ Kidney Transplant
- ❑ Liver Transplant
- ❑ Orthopedic Surgery - type:_________________ _________________
- ❑ Tubal Ligation
- ❑ Vascular Surgery
- ❑ Weight Loss Surgery
- ❑ Other (specify) ____________________ ____________________ ____________________ ____________________

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Winter Park, FL 32792

Health History Questionnaire

Patient Name: ____

Review of Systems (please check any current problems / symptoms you have experienced in the past month):

Constitutional	❑ Activity change ❑ Appetite change ❑ Chills ❑ Excessive sweating ❑ Fatigue ❑ fever ❑Unexpected weight loss
Ears, nose, mouth, throat and face	❑ Hearing loss ❑ Allergies ❑ Sinus problems
Eyes	❑ Cataracts ❑ Glaucoma ❑ Vision loss
Respiratory	❑ Stop breathing at night (sleep apnea) ❑ Asthma ❑ Cough ❑ Wheezing ❑ Shortness of breath ❑ Bronchitis
Cardiovascular	❑ chest pain ❑ Arrythmia ❑ High cholesterol ❑ Hypertension
Gastrointestinal	❑ Heartburn ❑ Liver problems ❑ Nausea ❑ Vomiting ❑ Ulcers
Genitourinary	❑ Kidney stones ❑ Dysuria (painful urination) ❑ Blood in urine ❑ Kidney disease
Female Patients Only	❑ Abnormal PAP ❑ Pelvic pain ❑ Endometriosis
Musculoskeletal	❑ Joint pain ❑ Back pain ❑ Osteoporosis
Skin	❑ Eczema ❑ Rash ❑ Psoriasis ❑ Keloid
Neurologic	❑ dizziness ❑ headaches ❑ seizures ❑ Fainting ❑ Tremor ❑ History of Stroke
Hematologic (blood)	❑ swollen lymph nodes ❑ bleed or bruise easily ❑ History of venous thrombosis

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Health History Questionnaire

Patient Name: ____

Family History

Check below to report problems your family members have had.

❑ **I was adopted and do not know my family history.**

	Father	Mother	Sister	Brother	Grandmother	Grandfather	Other (list)
Colon cancer & Age at diagnosis							
Colon Polyps							
Breast Cancer							
Other Cancer Type?							
Diabetes							
Heart attack							
Hypertension							
Ulcerative Colitis or Crohn's Disease							
Other : (specify)							
Alive? Y or N or NA							

Are you sexually active? Yes ❑ No ❑ If Yes, is your partner ❑ Male ❑ Female

Do you use illicit drugs? ❑ Yes ❑ No

If Yes, what kind of drugs do you use? ______________________________ **How Often?**______________________

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**

____

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

Insurance Non-Coverage Advance Notice Waiver

Please be advised:

Some health insurance plans will only pay for services that they determine to be reasonable and necessary. If an insurance plan determines that a particular service, although it would otherwise be covered, is not 'necessary and reasonable', the insurance plan may deny payment for that service.

If your health insurance plan denies payment for office consultation for screening procedures and/or some procedures you will be responsible for payment.

Policy/Patient Agreement

I ________________________________ have been informed on this date _____________ by my physician and/or staff that my health plan may deny payment for the service recommended. If the health plan denies payment, I agree to be personally and fully responsible for payment of the service(s) rendered.

Further, I will pay for these services within thirty (30) days of insurance denial, understanding that the physician will attempt to re-bill my insurance(s) on my behalf. If the physician is paid by my insurance, I will receive a refund for the portion of the bill covered by my insurance less any portion of the payment that is deemed my responsibility.

____

Policyholder/Patient Signature Date

____

Witness/Staff Signature Date