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

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

Other (specify)

_____

_____

_____

_____

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

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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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Jacqueline L. Kaiser, MD
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Winter Park, FL 32792

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 looby) 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-hour notice when you are not able to make your appointment. We reserve the right to charge a $25 fee for any missed office appointments. Additionally, we require a 72-hour notice when cancelling a surgical appointment. an additional fee of $100 for any missed surgical appointments, including but not limited to colonoscopy, sigmoidoscopy and 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 40% 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

Winter Park Colon & Rectal Specialists
Jacqueline L. Kaiser MD

Consent for Anorectal Examination and Treatment

Part of your evaluation may include an anorectal examination. This may include, but is not limited to:

- **Digital rectal examination**: insertion of a gloved finger into the anal area
- **Anoscopy**: insertion of an instrument into the anus
- **Proctosigmoidoscopy/ Flexible Sigmoidoscopy**: insertion of an instrument into the rectum and lower portion of your colon.
- For women, with certain conditions, this may also include a limited vaginal examination including
    - Insertion of a gloved finger into the vagina
    - Insertion of a speculum to examine the vagina

These tests are used to look for abnormal growths (such as tumors or polyps), inflammation, bleeding, hemorrhoids, and other conditions. During this examination you are also consenting to treatment of certain anorectal conditions including, but not limited to, hemorrhoids, anorectal growths or lesions, and infections.

I understand and consent to a **"MEDICALLY INDICATED ANORECTAL EXAMINATION INCLUDING BUT NOT LIMITED ALL MODALITIES LISTED ABOVE"**. This may be performed by one of our doctors, and/or a designated representative, all of whom will be identified to you in advance. This consent will remain active until I withdraw my consent in writing.

Consentimiento para Examen y Tratamiento Anorectal

Parte de su evaluación puede incluir un examen anorectal. Esto puede incluir, pero no se limita a:

- Examen rectal digital: inserción de un dedo enguantado en el área anal.
- Anoscopia: inserción de un instrumento en el ano.
- Proctosigmoidoscopia/sigmoidoscopia flexible: inserción de un instrumento en el recto y la parte inferior de su colon.
- Para las mujeres, con ciertas condiciones, esto también puede incluir un examen vaginal limitado que incluye
    - Inserción de un dedo enguantado en la vagina
    - Inserción de un espéculo para examinar la vagina.

Estas pruebas se usan para buscar crecimientos anormales (como tumores o pólipos), inflamación, sangrado, hemorroides y otras afecciones. Durante este examen, también está de acuerdo con el tratamiento de ciertas afecciones anorectales que incluyen, entre otras, hemorroides, crecimientos o lesiones anorectales e infecciones.

Entiendo y acepto un "EXAMEN ANORECTAL MEDICAMENTE INDICADO, INCLUYENDO PERO NO LIMITADO TODAS LAS MODALIDADES ANTERIORES". Esto puede ser realizado por uno de nuestros médicos, y / o un representante designado, todos los cuales serán identificados por adelantado. Este consentimiento permanecerá activo hasta que retire mi consentimiento por escrito.

Name/Nombre: _____ Date/Fecha: _____

Signature/Firma: _____

Witness Signature/Firma de Testigo: _____

255 N. Lakemont Ave #100, Winter Park, FL 32792 T: 407-628-1718 F: 407-628-0925

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

Colonoscopy Categories
What you need to know

The Affordable Care Act passed in March 2010 allowed for several preventative services, such as colonoscopies, to be covered at no cost to the patient. However, there are many caveats that prevent patients from taking advantage of this provision. One example is a "grandfather" clause; where insurance companies have two years before offering preventative services at no cost. There are now strict and changing guidelines on which colonoscopies are defined as a preventative service (screening.) These guidelines may exclude many patients with gastrointestinal histories from taking advantage of the service at no cost. Patients may be required to pay co-pays and deductibles.

Our practice has created this document to sort through some of the confusion and misinformation. Here is what you need to know about ***Colonoscopy Categories***:

1.) **Preventative Colonoscopy Screening**

The patient is asymptomatic (no gastrointestinal symptoms either past or present); over the age of 50, has no personal or family history of gastrointestinal disease, colon polyps and/or cancer.

2.) **Surveillance / High Risk Screening Colonoscopy**

The patient is asymptomatic (no present gastrointestinal symptoms), has a personal and/or family history of colon polyps and/or cancer. Patients in this category are required to undergo colonoscopy surveillance at shortened intervals (e.g. every 2-5 years).

3.) **Diagnostic / Therapeutic Colonoscopy**

The patient has past and / or present gastrointestinal symptoms, polyps or gastrointestinal disease.

Your primary care physician may refer you for a "screening" colonoscopy; however, you may not qualify for the "screening" category. This is determined in the pre-operative process. Before the procedure, you should know your colonoscopy category. After establishing what type of procedure you are having you can do some research.

Please choose one of the following reasons for your visit:

☐ **Preventative Colonoscopy Screening**
I ***DO NOT*** have any symptoms
I ***DO NOT*** have any personal or family history of colon cancer, polyps and/or gastrointestinal disease.

☐ **High Risk Screening**
I ***DO NOT*** have any symptoms.
I have a personal or family history of colon cancer, polyps, and/or gastrointestinal disease.

☐ **Diagnostic / Therapeutic Colonoscopy**
I have a symptom(s) and/or diagnosis and need to discuss undergoing a colonoscopy.

Disclaimer: The preventive service portion of The Patient Protection and Affordable Act only applies to your colorectal screening service. An evaluation and treatment of any sign, symptom and or colorectal disease in our office will be processed under your regular insurance benefits; therefore, out of pocket expenses may apply.

Patient Name:_____ Signature:_____

Date:_____

Winter Park Colon and Rectal Specialists, LLC

Jacqueline L. Kaiser, MD

255 North Lakemont Ave #100
Winter Park, FL 32792
407-628-1718

Consent to Receive Text Messages and Emails

By signing below, I authorize Winter Park Colon and Rectal Specialists, LLC (WPCRS) through our vendors, Twistle and Relatient to contact me by SMS text message and/or phone calls and/or email to serve me better. WPCRS will send me text messages, phone calls or emails through these services for the following:

Reminders of upcoming appointments and
Reminders regarding the steps during your colonoscopy prep.

I understand that message/data rates may apply to messages sent to my cell phone and that I may receive multiple messages.

I understand that I am under no obligation to authorize WPCRS to send me these messages and I may opt out of receiving them at any time by calling the office at (407)628-1718 or by texting "STOP" in response to any text message received.

Name:_____

Signature:_____

Date:_____