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Patient Information

Date________________________________

Patient Name ____
Last Name First Name Full Middle Name

Date of Birth ______/______/______ Age _______ Sex ◯ Male ◯ Female

Social Security number ________-______-_______

Home Address ____

____

Home Phone (_______)__________________ Primary Care Physician (PCP)________________________
Last Name First Name

Work Phone (_______)__________________ PCP's Phone Number(_____)__________________

Cell Phone (_______)__________________ Emergency Contact________________________

Email Address ______________________@_____________ Relationship________________________Phone______________________

Your Employer____
◯ Full-time ◯ Part-Time ◯ Retired

How were you referred to our practice?
◯ Physician, Name________________________________ ◯ Family ◯ Website ◯ Insurance ◯ Friend ◯ Internet Search ◯ Other________

Primary Insurance

Insurance Carrier ____

Member Id #__________________________________ Group # _____________________________________

Policy Holder Information

Name ____
Last Name First Name Full Middle Name

Date of Birth ________/________/_________ Sex ◯ Male ◯ Female Social Security Number ________-______-_________

Relation to Policy Holder ◯ Self ◯ Spouse ◯ Parent/Guardian ◯ Other (please specify) ________________

Secondary Insurance

Insurance Carrier ____

Member Id #__________________________________ Group # ________________________________

Policy Holder Information

Name ____
Last Name First Name Full Middle Name

Date of Birth ________/________/_________ Sex ◯ Male ◯ Female Social Security Number ________-______-_________

Relation to Policy Holder ◯ Self ◯ Spouse ◯ Parent/Guardian ◯ Other (please specify) ________________

HIPAA OMNIBUS RULE
PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM
ASSIGNMENT OF BENEFITS & PAYMENT/CREDIT AGREEMENT
(This is necessary to facilitate the processing of insurance claims and assure payment.)

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

1. I hereby authorize and give permission for Dr. Russell O. Schub, P.A., Advanced Endoscopy Center of Howard County, LLC and Advanced Anesthesia, LLC to disclose my personal health information (PHI)* for insurance and treatment purposes only. I am allowing Dr. Russell O. Schub, P.A., Advanced Endoscopy Center of Howard County, LLC and Advanced Anesthesia, LLC to release all PHI (private health information) necessary for payment and treatment of my specific health problem.
2. I hereby assign to you, my doctor, all medical and surgical benefits to which I am entitled, including Medicare, private insurance and any other insurance.
3. I understand that I am financially responsible for all charges not paid by said insurance company, including any deductibles and co-pays, and that payments are due at the time services are rendered.
4. I understand and agree that in the event that I fail to make payment for services rendered to me, my name and account may be turned over to an attorney or collection agency and I agree to pay collection agency's fees for collection, court costs, and/or reasonable attorney fees that may be incurred in the collection of an outstanding balance.
5. This office reserves the right to charge a handling fee for any unpaid balance.
6. Verification of benefits is not a guarantee of payment or coverage. All charges are subject to medical review and approval by my health plan. In the event coverage terminates or services are not covered, I acknowledge that I am responsible for all charges incurred based on contract provisions until its termination date.
7. The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.
8. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.**

I understand that I am financially responsible for all charges not paid by said insurance company, including any deductibles and co-pays, and that payments are due at the time services are rendered for office visits and 2 days prior to all scheduled procedures at Advanced Endoscopy Center of Howard County, LLC.

Cancellation fees - $200.00 cancellation fee for all procedures performed in Advanced Endoscopy Center that are cancelled or rescheduled within 3 days of the appointment.

__________________________ ____________________________ _______________
Please ***print*** your name   Please ***sign*** your name   Date

____________________________________ ____
Legal Representative   Description of Authority

Your comments regarding Acknowledgements or Consents:
____
____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):
Name: ____
Relationship: ______________________________________

Name: ____
Relationship: ______________________________________

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment _____
I could not communicate with the patient _____
The patient refused to sign _____
The patient was unable to sign because _____
Other (please describe) _____

____
Signature of Privacy Officer

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

☐ First Name Only ☐ Proper Surname ☐ Other ___________________________

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Email Confirmation
☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** (ie results or instructions from providers) BE CONVEYED VIA:

☐ Cell Phone - Leave message with information
☐ Home Phone - Leave message with information
☐ Work Phone - Leave message with information
☐ Email with health information
☐ **Any of the Above**
☐ **None of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

☐ Phone Message
☐ Email
☐ **Any of the Above**
☐ **None of the above** (opt out)

Patient Information

Name ____ Date_____________________
Race______________ Preferred Language________________

Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Patient declines to specify

Contact Preference: ❑ Letter ❑ Phone ❑ Patient Portal/Email ❑ Patient declines to specify

Our Patient Portal allows you to communicate with our practice and review your medical history.
Please click yes to indicate you consent to access information on line: ❑ Yes ❑ No

I consent to obtaining a history of my medications purchased at pharmacies: ❑ Yes ❑ No

Past or Present Medical Conditions- Please check any past or present medical conditions

◯ Anal Fissure	◯ Colitis	◯ Heart Attack	◯ Kidney Failure	◯ Rheumatic Fever
◯ Anemia	◯ Colon Cancer	◯ Heart Failure	◯ Kidney Infection	◯ Seizures
◯ Anesthesia Complications Breathing	◯ Colon Polyps	◯ Heart Murmur	◯ Kidney Stone	◯ Sexually Transmitted Diseases
◯ Anesthesia Complications Nausea/Vomiting	◯ Crohn's Disease	◯ Hemorrhoids	◯ Lung Cancer	◯ Skin Cancer
◯ Arthritis	◯ Depression	◯ Hepatitis A	◯ Migraines	◯ Sleep Apnea
◯ Asthma	◯ Diabetes	◯ Hepatitis B	◯ Milk Intolerance	◯ Spine/Back Problems
◯ Atrial fibrillation	◯ Diverticulitis	◯ Hepatitis C	◯ Mouth Ulcers	◯ Stomach Ulcers
◯ Back pain	◯ Duodenal Ulcer	◯ Herpes Zoster	◯ MRSA	◯ Stroke
◯ Bladder Disease	◯ Easy Bruising	◯ Hiatal Hernia	◯ Osteoporosis	◯ TB (Tuberculosis) Active Treated
◯ Bleeding Disorder	◯ Eczema	◯ High Blood Pressure	◯ Pancreatitis	◯ TB Skin Test Positive
◯ Blood Cancer	◯ Emphysema	◯ High Triglycerides	◯ Paralysis	◯ Thyroid Disease – Hyper
◯ Bone Fracture	◯ Esophageal Stricture	◯ HIV/AIDS	◯ Parkinson's Disease	◯ Thyroid Disease – Hypo
◯ Brain Cancer	◯ Fatty Liver	◯ Hives	◯ Phlebitis	◯ Ulcerative Colitis
◯ Bronchitis	◯ Frequent Urinary Infections	◯ Irregular Heartbeat	◯ Prostate Cancer	◯ Urinary/Bladder Infections
◯ Celiac Disease	◯ Gall Stones	◯ Irritable Bowel Syndrome	◯ BPH- enlarged prostate	◯ Valvular Heart Disease
◯ Chronic Lung Disease	◯ Glaucoma	◯ Jaundice	◯ PTSD	◯ Varices of Esophagus/Stomach
◯ Cirrhosis of Liver	◯ Gout	◯ Kidney Disease	◯ Reflux/GERD	Other_______________

Previous Surgeries

◯ None

◯ Anal Fissure Surgery When___________	◯ Angioplasty When___________	◯ Appendectomy When__________	◯ Cardiac defibrillator When__________	
◯ Cardiac surgery When__________	◯ C-Section When_________	◯ Cholecystectomy-gall bladder removal When___________	◯ Colon Resection When__________	
◯ Gastric By-Pass When__________	◯ Heart Valve Replacement When___________	◯ Hemorrhoidectomy When__________		
◯ Hernia Repair-Abdominal When___________	◯ Hiatal Hernia Repair When___________	◯ Hysterectomy When__________	◯ Liver Resection When___________	
◯ Lysis of Adhesions When___________	◯ Obesity Surgery When __________	◯ Pacemaker When__________	◯ Prostatectomy When __________	◯ Other ________________

Previous Procedures

◯ None

◯ Colonoscopy When__________	◯ Upper Endoscopy (EGD) When___________	◯ ERCP When__________	◯ Endoscopic US-internal gall bladder ultrasound When___________	◯ Liver Biopsy When___________

Review of Systems – Please **circle** any symptoms you are ***currently*** having

Allergic/ Immunologic
Persistent infections
Allergic reaction-wheeze,hive,itching

Constitutional
Chills
Fatigue
Fever
Loss of appetite
Sweats
Weight gain
Weight loss

Ear, Nose, Mouth Throat
Change in hearing
Change in vision
Difficulty swallowing
Dizziness
Double vision
Ear pain
Mouth Ulcers
Nasal Obstruction
Sore throat

Cardiovascular
Ankle swelling
Chest pain
Heart murmur
Irregular heart beats
Palpitations
Shortness of breath with exertion

Respiratory
Cough
Excessive sputum
Shortness of breath
Wheezing
Bloody sputum

Neurological
Dizziness
Fainting
Frequent headaches
Memory loss
Migraine
Numbness or tingling
Paralysis
Seizures
Tremors
Vertigo

Gastrointestinal
Abdominal bloating/swelling
Abdominal cramping
Abdominal pain
Anal pain
Belching
Change in bowel habits
Constipation
Dairy intolerance
Diarrhea
Excessive flatulence
Heartburn
Hemorrhoids
Mucous in stool
Nausea
Pain with bowel movement
Poor appetite
Rectal bleeding
Rectal pain
Rectal Urgency
Regurgitation
Soiling of Stools/Bowels
Trouble swallowing
Yellowing of skin/eyes
Vomiting
Vomiting Blood
Wheat/Gluten intolerance

Genitourinary
Blood in urine
Dark urine
Decrease in urine flow
Discharge
Frequent urinary infections
Frequent urination
Incontinence
Nighttime urination
Painful urination
Pain with intercourse
Sexual difficulty

Males
Prostate problems
Testicle problems

Females
Are you pregnant or could you be Pregnant?
Heavy periods
Breast lump(s)
Menopausal

Date of last menstrual period -

Are you menopausal?

Musculoskeletal
Arthritis
Back pain
Joint deformity
Joint pain
Joint swelling
Muscle pain
Muscle weakness
Stiffness

Skin
Dryness
Hives
Itching
Rashes

Endocrine
Excessive thirst
Hair loss
Heat intolerance
Cold Intolerance

Hematologic/lymphatic
Bleeding gums
Easy bruising
Enlarged lymph glands
Prolonged bleeding

Psychiatric
Anxiety
Depression
Difficulty sleeping
Hallucinations
Loss of interest in enjoyed activities
Nervousness
Panic attacks
Paranoia
Suicidal thoughts
Other

Other past medical problems

Lab or radiology testing recently done

◯ None

Other____

Immunizations

◯ Hepatitis B ◯ Flu ◯ Tetanus ◯ Pneumonia ◯ Other________________

Allergies

◯ No known allergies ◯ No known drug allergies

◯ Aspirin ◯ Codeine ◯ Diprovan/Propofol ◯ Fentanyl ◯ Iodine

◯ Latex ◯ Penicillins ◯ Sulfa ◯ Valium ◯ Versed

Other________________ Other________________ Other________________

Food Allergies ◯ Egg ◯ Nuts ◯ Soy Other________________

Social History

Occupation______________________________________ Number of children________________________________

Marital Status

◯ Single ◯ Married ◯ Divorced ◯ Widowed

Tobacco Smoking Status - please include type, quantity and frequency

◯ Current every day smoker ◯ Current occasional smoker ◯ Former smoker ◯ Never smoked

Type Started Quit Quantity Frequency

____

Alcohol

◯ None

◯ Social ◯ Daily ◯ Quit

Caffeine

◯ None

◯ Coffee ◯ Soda ◯ Tea ◯ Energy Drink Quantity__________________Frequency___________________________

Drug Use-Recreational

◯ None

Type Quantity Frequency

____

Family Medical History

◯ No knowledge of family medical history

Health status	Mother	Father	Sister	Brother	Grandmother-maternal	Grandmother-paternal	Grandfather-maternal	Grandfather-paternal	Other
Cancers									
Colon Cancer	◯	◯	◯	◯	◯	◯	◯	◯	◯
Esophageal Cancer	◯	◯	◯	◯	◯	◯	◯	◯	◯
Stomach Cancer	◯	◯	◯	◯	◯	◯	◯	◯	◯
Pancreatic Cancer	◯	◯	◯	◯	◯	◯	◯	◯	◯
Breast Cancer	◯	◯	◯	◯	◯	◯	◯	◯	◯
Other________________________	◯	◯	◯	◯	◯	◯	◯	◯	◯
Other									
Celiac Sprue	◯	◯	◯	◯	◯	◯	◯	◯	◯
Colitis	◯	◯	◯	◯	◯	◯	◯	◯	◯
Crohn’s Disease	◯	◯	◯	◯	◯	◯	◯	◯	◯
Diabetes	◯	◯	◯	◯	◯	◯	◯	◯	◯
Heart Disease	◯	◯	◯	◯	◯	◯	◯	◯	◯
High Blood Pressure	◯	◯	◯	◯	◯	◯	◯	◯	◯
Liver Disease	◯	◯	◯	◯	◯	◯	◯	◯	◯
Other________________________	◯	◯	◯	◯	◯	◯	◯	◯	◯

Medication List

Name_________________________________ Date of Birth ____________________

Today's Date ___________

Please complete the information below and <u>bring this form with you to your appointment.</u>

List all current medications that you currently take, including vitamins, over-the-counter medications and herbal preparations. ***<u>Make sure to include dosage and frequency</u>***

Medication Name (Please Print Legibly)	Dosage (mg)	Frequency (how often per day)	Check if need refill

Please fill out the pharmacy information completely, this information is used to electronically send your prescriptions.

Pharmacy Name____

Pharmacy Phone Number____

Pharmacy Address____

*******The above information is complete, true and correct to the best of my belief.*******

<u>Signature</u>

____

Signature Date

Rev. 8/19