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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) _____

Revised 1/2015/ss

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 and No show Policy - Patients who cancel or reschedule an office visit or testing appointment with less than 24 hours notice will be assessed a fee of $50.00.
*For Monday appointments, cancellations/rescheduling must be done by 12 pm the preceding Friday.

Patients who cancel or reschedule a procedure with less than 72 hours (3 business days) notice will be assessed a fee of $200.00.
*For Monday procedures, cancellations/rescheduling must be done by 12 pm the preceding Wednesday.

Patients who cancel or reschedule an infusion appointment with less than 72 hours (3 business days) notice will be assessed a fee of $150.00.
*For Monday procedures, cancellations/rescheduling must be done by 12 pm the preceding Wednesday.

_____ _____ _____
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	**Gastrointestinal**	**Musculoskeletal**
Persistent infections	Abdominal bloating/swelling	Arthritis
Allergic reaction-wheeze,hive,itching	Abdominal cramping	Back pain
	Abdominal pain	Joint deformity
Constitutional	Anal pain	Joint pain
Chills	Belching	Joint swelling
Fatigue	Change in bowel habits	Muscle pain
Fever	Constipation	Muscle weakness
Loss of appetite	Dairy intolerance	Stiffness
Sweats	Diarrhea	
Weight gain	Excessive flatulence	**Skin**
Weight loss	Heartburn	Dryness
	Hemorrhoids	Hives
Ear, Nose, Mouth Throat	Mucous in stool	Itching
Change in hearing	Nausea	Rashes
Change in vision	Pain with bowel movement	
Difficulty swallowing	Poor appetite	**Endocrine**
Dizziness	Rectal bleeding	Excessive thirst
Double vision	Rectal pain	Hair loss
Ear pain	Rectal Urgency	Heat intolerance
Mouth Ulcers	Regurgitation	Cold Intolerance
Nasal Obstruction	Soiling of Stools/Bowels	
Sore throat	Trouble swallowing	**Hematologic/lymphatic**
	Yellowing of skin/eyes	Bleeding gums
Cardiovascular	Vomiting	Easy bruising
Ankle swelling	Vomiting Blood	Enlarged lymph glands
Chest pain	Wheat/Gluten intolerance	Prolonged bleeding
Heart murmur		
Irregular heart beats	**Genitourinary**	**Psychiatric**
Palpitations	Blood in urine	Anxiety
Shortness of breath with exertion	Dark urine	Depression
	Decrease in urine flow	Difficulty sleeping
Respiratory	Discharge	Hallucinations
Cough	Frequent urinary infections	Loss of interest in enjoyed activities
Excessive sputum	Frequent urination	Nervousness
Shortness of breath	Incontinence	Panic attacks
Wheezing	Nighttime urination	Paranoia
Bloody sputum	Painful urination	Suicidal thoughts
	Pain with intercourse	Other
Neurological	Sexual difficulty	
Dizziness	**Males**	
Fainting	Prostate problems	**Other past medical problems**
Frequent headaches	Testicle problems	
Memory loss	**Females**	
Migraine	Are you pregnant or could you be Pregnant?	
Numbness or tingling	Heavy periods	
Paralysis	Breast lump(s)	
	Menopausal	
Seizures		
Tremors	**Date of last menstrual period -**	
Vertigo	**Are you menopausal?**	

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. 1/2020