5016 W. Cypress St.
Suite 200
Tampa, FL 33607
(813) 542-2589
www.Gastro-MD.com

NEW PATIENT REGISTRATION FORM

Last Name		First Name		MI	
Date of Birth (mm/dd/yyyy)		Today's Date			
Address					
City		State		Zip	
Email					
Home Phone		Cell Phone			
Work Phone		Other Phone			
Gender	M / F / Trans / Other	Social Security #		Marital Status	Married / Single / Widowed / Divorced
Who referred you to our practice?					
Primary Care Physician					

EMERGENCY CONTACT

Name		Phone #		Relationship	
Address					

INSURANCE INFORMATION

Primary Insurance Company		Secondary Insurance	

Person who is responsible for Insurance Account
(Person who holds the insurance policy or legal guardian of a minor. If you are the holder, you may skip this part)

Last Name		First Name		MI	
Home Phone		Cell Phone			
Work Phone		Other Phone			
Relationship to Patient		Social Security #			
Date of Birth (mm/dd/yyyy)		Gender	Male / Female / Trans / Other		
Employer		Occupation			

5016 W. Cypress St.
Suite 200
Tampa, FL 33607
(813) 542-2589
www.Gastro-MD.com

Name		Date	
Reason for Visit			

Current Medications	**Medication Allergies**	**Social History**				
		Have you ever smoked?	Y		N	
		Do you currently smoke?	Y		N	
		If yes, how much?				
		Do you drink alcohol?	Y		N	
		If yes, how much?				
		Any history of Illicit Drugs?	Y		N	

Family History (check all that apply)			
☐	←Heart Disease	☐	←Colon Cancer
☐	←Diabetes	☐	←Colon Polyps
☐	←Hypertension	☐	←Crohn's Disease
☐	←Stroke	☐	←Ulcerative Colitis
☐	Other:		

Colonoscopy/ EGD History	
Year of Latest Colonoscopy	
Year of Latest Upper Endoscopy EGD	

Past Medical History (check all that apply)			
☐	High Blood Pressure	☐	GERD/ Heartburn
☐	Stroke	☐	Diverticulosis
☐	Diabetes	☐	Hemorrhoids
☐	High Cholesterol	☐	Colon Polyps
☐	Congestive Heart Failure	☐	Fatty Liver
☐	Emphysema / COPD	☐	Hepatitis
☐	Asthma	☐	Anemia
☐	Depression	☐	Others:
☐	Seizures		
☐	Kidney Disease		
☐	Angina		
☐	Dialysis		
☐	Heart Disease→Details:		
☐	Prostate Problems→ Cancer / Enlarged		
☐	Thyroid Problems→ Hypothyroidism / Hyperthyroidism		
☐	Arthritis: Osteoarthritis or Rheumatoid		
☐	Cancer→ Type:		

Past Surgical History (check all that apply)	
☐	Heart Catheterization
☐	Open Heart Surgery
☐	Appendix Surgery
☐	Gallbladder Surgery
☐	Other Surgeries → Details:

5016 W. Cypress St.
Suite 200
Tampa, FL 33607
(813) 542-2589
www.Gastro-MD.com

Advanced Care Plan

Name	
Address	
Date of Birth (mm/dd/yyyy)	

If I cannot speak for myself, I would like my doctor to talk about my health care and medical problems to the following person/s: (please write their name and contact number/s):

Name	Phone Number

Signature _____

Printed Name _____

Date _____

5016 W. Cypress St.
Suite 200
Tampa, FL 33607
(813) 542-2589
www.Gastro-MD.com

Authorization for Treatment / Release of Information

Consent to Treatment: The patient and/or authorized representative do hereby consent to any and all medical treatment which may deem advisable by the physician(s) of Gastro MD.

Authorization for Release of Confidential Information: I hereby authorize Gastro MD to release medical information contained in my/the patient's records to any insurance carrier, employer or other third party intermediary utilized by the patients for the purpose of obtaining information and/or reviewing the record of medical care
eived by the patient for the payment of all medical charges. Copies of records may also be sent to referring physicians for continuity of care. Medical Records released may include any diagnostic or therapeutic information of visits and/or procedures performed in office. Unless initialed below the records may not include any confidential information regarding

_____*Alcohol/Substance Abuse* | _____*Mental Health* | _____*HIV*

According to the Health Insurance Portability and Accountability Act of 1996 (HIPAA):
The patient's medical record may not be furnished to and the medical condition of the patient may not be discussed with any other person than the patient, the patient's legal representative, or other health care practitioners involved in the care and treatment of the patient without the patient's written authorization. The patient may at this time authorize an individual to be actively involved in the patient's information as mention above.

Name:_____Relationship:_____

Assignment of Insurance Benefits: I assign payment directly to Gastro MD, the insurance benefits otherwise payable to me. I understand that I am financially responsible for charges not paid by this assignment, I will assist in the collection of my insurance should there be any delay in payment. I agree to actively pursue collecting insurance payment for any claims unpaid after (30) days. In after forty-five (45) days the claim remains unpaid, I understand the balance will be due from me.
Medicare Patients: I certify that the information given by me in applying the payment under title xvii of the Social Act is correct. I authorize Gastro MD to release to the Health Care Financing Administration or its carriers or intermediaries any information needed for this or related Medicare claim. I hereby authorize payment directly to Gastro MD for medical benefits otherwise payable to me as a beneficiary of the Medical Program and such other payments as may be due by other third party payers. I agree to execute such documents as may be necessary to apply for and obtain payment. I understand that such services as, but not limited to, routine testing may not be covered by Medicare unless the physician provides medical necessity.
Pre-Authorization: Your insurance company may require pre-authorization for office visits and/or procedures. I understand that if proper authorization is not obtained from my PCP (Primary Care Physician) I will be liable for charges incurred.

Patient/Guarantor Agreement: I understand that Gastro MD is not the business of extending credit. Therefore, it is the policy of Gastro MD to require payment in full at the time of service. If unable to pay patient due balance in full at the time of service, I agree to make prior arrangements with the billing department.

I understand that I am financially responsible for my/the patient's account with Gastro MD, regardless of my insurance benefits. I authorize a copy of this form to be valid as the original.

Patient/Responsible Party:_____Date:_____

5016 W. Cypress St.
Suite 200
Tampa, FL 33607
(813) 542-2589
www.Gastro-MD.com

Cancellation/No Show Policy for Provider Appointments and Procedures

We understand that there are times when you must miss an appointment or procedure due to emergencies or obligations for work or family. However, when you do not call to cancel, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" schedule.

1. ***Cancellation/ No Show Policy for Provider Appointment***

If an appointment is not cancelled at least 2 days in advance you will be charged a twenty-dollar ($20) fee; *this will not be covered by your insurance company!*

2. ***Late Arrival for Office Appointments***

We understand that delays can happen however we must try to keep the other patients and doctors on time.

If a patient is greater than 15 minutes past their scheduled time, we will have to reschedule the appointment.

3. ***Cancellation/ No Show Policy for Procedures***

In order to provide the most efficient scheduling to our patients, we need to keep appointment cancellation and "no show" activity to a minimum. To accomplish this a cancellation and "no-show fee will be charged to the patient if procedures are canceled without proper advance notice, or if the patient does not show up for a scheduled procedure.

If procedures are not cancelled at least 5 business days in advance you will be charged:

- Colonoscopy and / or Endoscopy will be $200
- Capsule Endoscopy will be $100
- Anal Manometry will be $100
- Biofeedback Therapy will be $100
- Hemorrhoid Treatments will be $20

As a courtesy, we make every effort to remind patients of their office visit by telephone 3-4 business days before the appointment date. These are not calls to confirm the appointment, but are calls to remind the patient of their appointment. It is your responsibility to provide us with the appropriate advance notice if you need to cancel an office visit. Cancellations can be made at ANY time by calling 386-668-2221 and leave a message if necessary.

This fee will not be covered by your insurance company!

_____	_____	___/___/___
Print Name	**Patient Signature/Guardian**	**Date**

Revised: 2/16/2021