CITRUS GASTROENTEROLOGY, P.A.
3653 E. FOREST DRIVE • INVERNESS, FL 34453-0787 • TEL (352) 344-8080 • FAX (352) 344-0631
E-Mail: citrusgi@tampabay.rr.com

Patient Information Form

Date _____

Last Name _____ First Name _____ MI _____

Mailing Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Date of Birth _____ Age _____ Gender _____ Male _____ Female

Religious Preference _____ Social Security Number _____

Referring Physician _____ Physician Phone _____

MARITAL ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated **RACE** ☐ African American ☐ American Indian/Alaskan Native

☐ Asian/Pacific Islander ☐ Hispanic ☐ White/Caucasian ☐ Other _____

EMPLOYMENT ☐ Full-time ☐ Part-time ☐ Retired ☐ Disabled ☐ Unemployed **STUDENT** ☐ Full-time ☐ Part-time

Employer _____ Phone Number _____

Employer Address _____ City/St/Zip Code _____

Name of Spouse or Responsible Party _____

Primary Insurance
Company Name _____ Phone Number _____

Billing Address _____ City/St/Zip Code _____

Name of Insured and Relation to Patient _____

Insured's ID Number _____ Group Number _____ **Subscriber's DOB:** _____

Secondary Insurance
Company Name _____ Phone Number _____

Billing Address _____ City/St/Zip Code _____

Name of Insured and Relation to Patient _____

Insured's ID Number _____ Group Number _____ **Subscriber's DOB:** _____

PLEASE COMPLETE FORM ON REVERSE SIDE

ADVANCE DIRECTIVE:

() I DO HAVE A LIVING WILL **() I DO NOT HAVE A LIVING WILL**

ON THE DAY OF YOUR APPOINTMENT PLEASE BRING A COPY OF YOUR ADVANCE DIRECTIVE TO BE FILED IN YOUR MEDICAL RECORD. THANK YOU.

E-Mail Address: _____

Can we contact you via e-mail? Yes _____ **No** _____

Person who does not live with you to contact in the case of an emergency:

Name _____ Phone Number _____

Address: _____ City/St/Zip Code _____

If you are a seasonal resident please provide us with your secondary address:

Secondary Mailing Address: _____

City _____ State _____ Zip _____

Charges incurred for services rendered in this office are the patient's responsibility, regardless of insurance coverage. Assignment will be accepted for all insurances with which the physicians of this practice participate. For all other insurances, assignment can be considered on a case-by-case basis. IT IS THE PATIENT'S RESPONSIBILITY TO PROVIDE THIS OFFICE WITH ACCURATE INSURANCE INFORMATION, AND TO NOTIFY US OF ANY CHANGES IN HEALTH INSURANCE COVERAGE.

I hereby authorize payment of medical benefits billed to my insurance to Citrus Gastroenterology, P.A. I hereby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I also accept responsibility for fees that exceed the payment made by my insurance, if the Practice does not participate with my insurance.

I agree to pay all co-payments, co-insurance and deductibles at the time the service is rendered.

I will pay by (check one) ☐ cash ☐ check ☐ credit card ☐ debit card

_____ _____

Signature of patient or guardian Date

Citrus Gastroenterology, P.A

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NAME: _____ DOB: _____ SEX: _____

PRIMARY CARE PHYSICIAN: _____

MEDICAL HISTORY	SURGICAL HISTORY

DO YOU TAKE ANY BLOOD THINNERS OR ASPIRIN DAILY: YES NO REASON: _____

MONITORING PHYSICIAN: _____

REVIEW OF SYMPTOMS: CHECK IF SYMPTOMS APPLY

CONSTIPATION	DIFFICULTIES SWALLOWING	BLOOD IN STOOL	DEPRESSION
FATIGUE	DIARRHEA	FREQUENT URINATION	VOMITING
FEVER	HEART BURN	BLOOD IN URINE	CARPAL TUNNEL
HEADACHE	NAUSEA	DIFFICULTIES URINATING	SCIATICA
CHEST PAIN	RECTAL BLEEDING	SHORTNESS OF BREATH	ANXIETY

FAMILY HISTORY: PLEASE LIST IF THESE FAMILY MEMBERS ARE ALIVE OR DECEASED THEIR CAUSE OF DEATH & ANY MEDICAL CONDITIONS

MOTHER	ALIVE /	DECEASED
FATHER	ALIVE /	DECEASED
BROTHER / SISTER	ALIVE /	DECEASED
BROTHER / SISTER	ALIVE /	DECEASED
BROTHER / SISTER	ALIVE /	DECEASED
SON/DAUGHTER	ALIVE /	DECEASED
SON/DAUGHTER	ALIVE /	DECEASED

DO YOU HAVE ANY FAMILY HISTORY FOR ANY CANCER? YES OR NO IF YES WHAT TYPE OF CANCER AND WHO?

_____

SOCIAL HISTORY: PLEASE CIRCLE THE ONE THAT APPLYS

SMOKE: YES NO QUIT ALCOHOL: YES NO QUIT CAFFEINE: YES NO

TATTOOS: YES NO BLOOD TRANSFUSION YES (YR) NO

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PLEASE LIST ALL MEDICATIONS:

NAME	STRENGTH	TIMES PER DAY

DRUG ALLERGIES: PLEASE LIST ALL ALLERGIES YOU MAY HAVE TO ANY MEDICATIONS AND YOUR REACTION

MEDICATION	*REACTION*

PATIENT NAME (print) _____

SIGNATURE

_____

Citrus Gastroenterology, P.A.
3653 E Forest Drive, Inverness, FL 34453

We want to take this opportunity to welcome you to our practice and thank you for choosing us to provide you with your medical care. Dr. Johannes Martensson has been with this practice since 1996. He is a specialist in the field of Gastroenterology and Hepatology. We are please to announce the addition of Agda Hart, Physician Assistant trained in Gastroenterology. Our nursing and business staff are here to assist you with any concerns, billing and/or insurance questions you may have or any issues regarding your protected health information or privacy issues with this office.

Our Financial Policy

Kindly know that we will make every effort to work with your health insurance company. Therefore, as a courtesy we will file all health insurance claims for you. However, health insurance is considered a method of reimbursing the patient for fees paid to the doctor and not a substitute of payment. Some insurance companies pay fixed allowances while others pay on a percentage basis. At the time of your service with us you will be responsible for any co-payments, deductible or balance assessed by your health insurance carrier. Any health insurance claims not paid within 45 days of submission will become patient responsibility.

In the case that the patient is uninsured payment is required at the time of service, unless other payment arrangement have been made.

On the date of your first visit with us please bring the following:

- Enclosed packet (completed and signed)
- Health insurance cards
- Photo ID (drivers license)
- Copy of Advanced Directive (if you have one)
- Payment Method for your visit
- List of all medications that you are currently taking.

I have read and acknowledge the above financial policy.

Patient Signature	Patient Name	Date
Witness Signature	Witness Name	Date

PLEASE COMPLETE FORM ON REVERSE SIDE

Citrus Gastroenterology, P.A.
3653 E Forest Dr , Inverness, FL 34453

Medicare Certification/Lifetime Authorization

I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize the release of medical or other information about me to the Social Security Administration or it intermediaries/carriers necessary for Medicare claims. I request that payment of authorized benefits be made on my behalf. I permit a copy of the authorization to be used in place of the orginial and request payment of medical insurance benefits to Citrus Gastroenterology, P.A., who is accepting assignment on my behalf for all Medicare claims. This authorization remains valid for lifetime or until otherwise revoked by myself in writing.

Medigap or Other Commercial Insurance Release of Information and Assignment of Benefits

I hereby authorize Citrus Gastroenterology, P.A., to release any information contained in my medical file to my insurance company on file, relative to claims made on my behalf. I further authorize payment of all claims directly to Citrus Gastroenterology, P.A. This authorization remains valid for lifetime or until otherwise revoked by myself in writing.

_____ _____

Signature of Patient or Patient's Representative Date

_____ _____

Printed Name of Patient or Patient's Representative Relationship to Patient

Citrus Gastroenterology, PA
3653 East Forest Dr
Inverness, Fl 34453

PATIENT CONSENT FORM FOR CARE AND TREATMENT

The undersigned consents to the medical care and treatment, as may be deemed necessary or advisable in the judgement of the physician or other provider, which may include but are not limited to laboratory procedures, X-ray examination, medical or surgical treatment or procedures or other services rendered to the patient under the general and special instructions of the patient's physician.

Assignment of Insurance Benefits
I authorize payment directly to practice of any insurance benefits otherwise payable to me for services, at a rate not to exceed the practices' regular charges for such services.

Privacy – Uses and Disclosures of Patient Information
The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations. As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment of health care operations, in order to provide health care that is in your best interest. We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as labs that only interact with physicians not patients),and may disclose personal health information for purposes of treatment, payment or health care operations. These entities are most often not required to obtain patient consent. You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we hate the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information, (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent. If you have any objection to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our privacy notice, to request restriction and revoke consent in writing after you have reviewed our privacy notice.

Printed Name: _____

Signature: _____

Date: _____

PLEASE COMPLETE REVERSE SIDE OF THIS FORM

Citrus Gastroenterology, P.A.
3653 E Forest Drive, Inverness, FL 34453

Disclosure of Protected Health Care Information:

Please be advised that one of the requirements under HIPAA federal privacy laws requires you to authorize/designate below which individuals (relatives, this includes your spouse or significant other, and /or friends) we can speak with about your healthcare treatment, healthcare payments, and healthcare operations.
I designate/authorize the following individuals:

Name _____ Relationship_____ Phone _____

Name _____ Relationship_____ Phone _____

Name _____ Relationship_____ Phone _____

I understand I can change or revise my designees at any time by notifying Citrus Gastroenterology, P.A. in writing.

Citus Gastroenterology PA
3653 E Forest Drive
Inverness, FL 34453

I _____ hereby acknowledge that I have reviewed and received a copy of this practice's Notice of Privacy Practices, which has been updated for the new Omnibus Rule and has an effective date of 02/01/2018.

The notice describes:

- the ways that the Privacy Rule allows our practice to use and disclose protected health information. How our practice will get your permission, or authorization, before using your health records for any other reason.
- the practice's duties to protect health information privacy.
- the patient's privacy rights, including the right to complain to HHS and to the covered entity if you believe your privacy rights have been violated.
- how to contact our practice for more information and to make a complaint.

I understand that the Notice of Privacy Practices may be revised from time to time and that I have a right to receive an updated copy upon request.

_____
PATIENT SIGNATURE

_____
DATE

AUTHORIZATION TO USE AND/OR DISCLOSE MEDICAL RECORDS

I give authorization to the provider listed below to disclose a copy of the specific health/medical information identified below:

NAME OF PATIENT			
DATE OF BIRTH		SS#	

TO: (Name, Address, Phone of Recipient of Records)						
Name	Citrus Gastroenterology, PA			Phone	352-344-8080	
Address	3653 E Forest Drive					
City/State Zip	City	Inverness	State	FL	Zip	34453

RECORDS FROM: (Who is Releasing the Records)						
Name				Phone		
Address						
City/State Zip	City		State		Zip	

For the Following Purposes:

	Continued Medical Care		Personal Information		Legal Follow-up
	Disability Insurance		Other:		

By Checking the Boxes Below, I Specifically Authorize the Use and/or Disclosure of the Following Health Information And/or Medical Records, If Such Information And/or Records Exist:

	Please send the entire Medical Record (all information) to the above named recipient.				
	Office Notes and Reports		Diagnostic Reports		Billing Statements
	Rx History		Transcribed Hospital Reports		Laboratory Reports
	Others Listed Here:				

The Following Items Must Be Initialed to Be Included in the Use And/or Disclosure:

_____ HIV/AIDS relate information and/or records HBV, TB or Other Communicable Diseases

_____ Mental Health Information and/or Records

_____ Domestic Violence

_____ Genetic Testing Information and/or records

_____ Drug/Alcohol diagnosis, treatment or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed.) Describe:

_____

_____ Other: _____

I understand that, if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by HIPAA and other federal and state regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I also understand that the person I am authorizing to use and/or disclose the information may not receive compensation for doing so.

I, further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment of my eligibility for benefits. I may inspect or copy any information to be used and/or disclosed under this authorization.

Finally, I understand that **I may revoke this authorization**, in writing, at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization. Unless Revoked Earlier, this Authorization Will Expire in Six (6) Months from the Date of Signing or until (Insert Date): _____.

Print Patient's Name: _____ Date: _____

Signature of Patient or Patient's Legal Representative: _____

Print Name of Legal Representative (if applicable): _____

Relationship to patient: _____