PATIENT INFORMATION FORM

PRIMARY CARE DOCTOR _____ PRIMARY CARE DOC. PH# _____ FAX# _____

NAME _____ SEX ☐ M ☐ F

SOCIAL SECURITY # _____ BIRTHDATE _____ MARITAL STATUS ☐ S ☐ M ☐ W ☐ D

RELIGION _____ AGE _____ PH. NUMBER ( ) _____

STREET ADDRESS _____ APT. _____

CITY _____ STATE _____ ZIP _____

* E-MAIL _____

EMPLOYER/SCHOOL _____ TITLE _____ PHONE # ( ) _____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____

SPOUSE _____ AGE _____ BIRTHDATE _____

SPOUSE EMPLOYER _____ TITLE _____ PHONE # ( ) _____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____

TRANSLATOR NEEDED ☐ YES ☐ NO PRIMARY LANGUAGE SPOKEN _____ REFERRED BY: _____

SOMEONE TO CONTACT LOCALLY IN CASE OF EMERGENCY, OTHER THAN SOMEONE LIVING WITH YOU:

NAME _____ PHONE ( ) _____ RELATIONSHIP _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

IF PATIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING:

FATHER'S NAME _____ MOTHER'S NAME _____

EMPLOYED BY _____ EMPLOYED BY _____

POSITION _____ POSITION _____

PHONE _____ PHONE _____

PRIMARY INSURANCE INFORMATION

INSURANCE CO. _____

ADDRESS _____

CITY / STATE / ZIP _____

PHONE # _____

I.D. # _____

GROUP NAME OR # _____

INSURED'S FULL NAME _____

IS THIS AN EMPLOYER PLAN? _____

INSURED'S SOCIAL SEC. # _____

INSURED'S D.O.B _____

RELATIONSHIP TO INSURED _____

(Self— Husband— Wife— Child— Other)

SECONDARY INSURANCE INFORMATION

INSURANCE CO. _____

ADDRESS _____

CITY / STATE / ZIP _____

PHONE # _____

I.D. # _____

GROUP NAME OR # _____

INSURED'S FULL NAME _____

IS THIS AN EMPLOYER PLAN? _____

INSURED'S SOCIAL SEC. # _____

INSURED'S D.O.B _____

RELATIONSHIP TO INSURED _____

(Self— Husband— Wife— Child— Other)

GUARANTEE OF PAYMENT

I fully understand that I am directly responsible for payment to the Physicians in this office for all medical services rendered to me. I also understand that all bills are payable and become due at the time services are rendered, unless other arrangements have been made. I agree to pay all collection costs including reasonable attorney's fees and costs in the event it becomes necessary to file suit to effect payment. I authorize payments to be made directly to my doctor.

AUTHORIZATION TO RELEASE INFORMATION

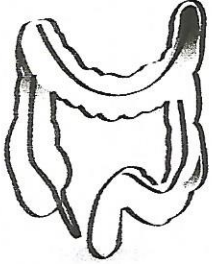
I hereby authorize the Physicians in this office to release any information acquired in the course of my examination or treatment to my insurance company for the purpose of processing any insurance claim.

ASSIGNMENT OF INSURANCE BENEFITS

If insurance claims are filed by this office on my behalf, I hereby authorize direct payment of any benefits to the Physicians in this office for medical or surgical treatment received by me. In this circumstance, I understand that I am financially responsible for any charges not covered by insurance. I permit a copy of the authorization to be used in place of the original.

Signature _____ Date _____

(Patient's parent, if minor)



THE COLON AND RECTAL CLINIC

FT. LAUDERDALE | Committed to Excellence in Surgical Care of the Colon and Rectum.

Westside Specialty Center • 350 N. Pine Island Road • Suite 300 • Plantation, FL 33324

Medical Arts in the Springs • 2901 Coral Hills Drive • Suite 360 • Coral Springs, FL 33065

* Phone: (954) 236-5444 * Fax: (954) 236-5422 *
www.crcftlauderdale.com

Charles P. Lago, Sr., M.D., F.A.C.S., F.A.S.C.R.S. **Joseph P. Corallo, Jr., M.D.**

Name:_____ Date: _____

Referring Physician (Complete Name) _____

***What one symptom brought you here today:** _____

Please list allergies:_____

_____

Please list Medications:_____

_____

Please list previous surgeries: _____

_____

Please list pertinent family history (such as colon cancer/polyps, breast cancer, etc.): _____

_____

_____

Have you ever used tobacco? If yes, how much? _____

Alcohol intake (amount used daily, weekly or monthly):_____

Have you lost weight? _____ How much? _____ Since when? _____

Have you had PROBLEMS with any of the following? (circle all that may pertain):

1. High blood pressure	7. Liver disease	13. Pancreatitis	19. Skin conditions	25. Problems with general Anesthesia?
2. Diabetes	8. Peptic Ulcer	14. Gallbladder	20. Thyroid	26. Problems with local Anesthesia?
3. Heart disease	9. Hiatal hernia	15. Arthritis	21. Hormonal/Uterine	27. Cancer-Where? _____
4. Kidney disease	10. Gastritis	16. Lung disease	22. Ophthalmologic	28. Colonoscopy_____
5. Urinary track	11.Collitis	17. Psychiatric	23. Orthopedic	29. Other _____
6. Prostate problems	12. Diverticulitis	18. Neurological	24. Bleeding	_____

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Charles P. Lago, Sr., M.D., F.A.C.S., F.A.S.C.R.S.

Joseph P. Corallo, Jr., M.D.

To: _____

Phone: _____ Fax: _____

I, _____ , authorize you to
(please print)

furnish a copy of my medical records to the Colon & Rectal Clinic of Ft. Lauderdale. I release you from all legal responsibility or liability that arises from this authorization.

Comments: _____

*********Patient Signature _____

Date of Birth_____ SS#_____

Witness _____ Date_____

Payments, co-payments, and deductible amounts are due at the time of service unless special arrangements have been made. The billing department will gladly file insurance claims on my behalf; however payment cannot be guaranteed. I understand that the billing department will make every effort and several attempts to obtain payments and/or clarify my insurance carrier's decisions regarding my outstanding balance. In the event that the insurance company misquoted my benefits, my benefits changed, or any other reason that the insurance company denies my claim, I will be responsible for any unpaid balances not covered by my insurance company. I will also be responsible for a $25 charge for any checks returned for insufficient funds.

Patient's Signature: Date:

Parent/Guardian's Signature: Date:

I am also acknowledging my understanding that since my appointment time has been set aside exclusively for me, that I am responsible for notifying my practitioner 24 hours in advance to avoid a $25 cancellation fee. I am aware that my insurance company will not pay for missed appointments.

Patient's Signature: Date:

Parent/Guardian's Signature: Date:

*PLEASE RETURN WITH YOUR PAPERWORK

Patient Acknowledgement

I acknowledge that I have been provided with The Colon and Rectal Clinic of Fort Lauderdale, PA **PRIVACY NOTIFICATION** and that I have read and fully understand the notice.

Patient Name (Print)_____

Patient Signature_____ Date_____

WitnessSignature_____

*Spouse/Family/Friend_____

*If anyone calls on your behalf, we cannot talk to them unless their name is on this form or if you need your records picked up.

HIPAA Notice of Privacy Practices

Revised 2013

Effective as of April/14/2003
Revised March/26/2013

Colon and Rectal Clinic of Fort Lauderdale, PA
350 North Pine Island Road, Suite 300
Plantation, FL 33324
954-236-5444

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made **only with your consent, authorization** or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Pursuant to your written request, you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request.

You have the right to receive notice of a breach – We will notify you if your unsecured protected health information has been breached.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

954-236-5444

HIPAA COMPLIANCE OFFICER Phone email

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.