Colon & Rectal Associates

PATIENT GENERATED MEDICAL HISTORY

Name: _____ DOB: _____ Email: _____ Date: _____

PCP: _____ Referring: _____ Copies to: _____

Pharmacy: _____ Pharmacy Phone #: _____

Directions: Please circle any of the following you have personally had during your life:

YOUR PAST MEDICAL HISTORY:

Asthma
Emphysema / COPD
Blood Transfusion Date: _____
Cancer:

Breast Cancer
Colon Cancer
Esophageal Cancer
Liver Cancer
Lung Cancer
Other Cancer _____
Ovarian Cancer
Pancreatic Cancer
Stomach Cancer
Uterine Cancer

Congestive Heart Failure
Coronary Artery Disease
Crohns Disease/Ulcerative Colitis
Diabetes Mellitus: Type 1 Type 2
GERD
High Blood Pressure
Irritable Bowel Syndrome
Liver Disease
Pancreatitis
Sleep Apnea / CPAP machine Y / N
Ulcer Disease
Other _____

ALLERGY	REACTION

LAST MENSTRUAL PERIOD _____

Could you be pregnant? Y / N

YOUR PAST SURGICAL HISTORY:

	Date
Appendectomy	_____
Artificial Heart Valve	_____
Artificial Joint	_____
Bowel Obstruction	_____
Bowel (repair/resection)	_____
CABG/Heart Bypass Vessels _____	_____
C-Section	_____
Gallbladder removal	_____
Hysterectomy Total Partial	_____
Neck Artery/Vascular Surgery	_____
Pancreatic Surgery	_____
Surgery for Reflux/Hiatal Hernia	_____
Surgery for Ulcers	_____
Last Colonscopy	_____
Other _____	_____

MEDICAL PROBLEMS LIST / REASON FOR VISIT

_____

_____

_____

YOUR SOCIAL HISTORY:

Occupation _____ Working / Retired

Tobacco? Y/N Type: _____

Qty: ____ # of Yrs. Smoked _____ Former ____

Alcohol: Y/N Drinks/Day _____ Social _____

Former _____ Yr. Stopped _____

Recreational Drug use: Y / N Type: _____

Marital Status: M S D W L

Children #: Y/N boys: _____ girls: _____

Directions: Please circle any of the following that exists in your family.

YOUR FAMILY HISTORY:

TYPE	RELATIONSHIP	Paternal/ Maternal	AGE
Cancer, Breast	_____	P/M	_____
Cancer, Colon	_____	P/M	_____
Cancer, Ovary	_____	P/M	_____
Cancer, Uterus	_____	P/M	_____
Cancer _____	_____	P/M	_____
Colon Polyps	_____	P/M	_____
Crohn's Disease	_____	P/M	_____
Pancreatic Dis.	_____	P/M	_____
Ulcerative Colitis	_____	P/M	_____
Ulcers	_____	P/M	_____

				AGE
Mother:	Alive	Y/N	If no, cause _____	_____
Father:	Alive	Y/N	If no, cause _____	_____
Sister:	Alive	Y/N	If no, cause _____	_____
Brother:	Alive	Y/N	If no, cause _____	_____

Other Diseases That Run In The Family: _____

_____

_____

Colon & Rectal Associates

MEDICATION LOG

NAME: _____ DOB: _____

DIRECTIONS: Please list any over the counter or prescribed medications you currently take.

Drug Name	Dosage	Start Date	Why do you take the medicine?	Drug Name	Dosage	Start Date	Why do you take the medicine?

Colon & Rectal Associates

GI REVIEW OF SYSTEMS - FEMALE

NAME: _____ DOB: _____

Directions: Have you had any of the following in the last three months?

CONSTITUTIONAL

NO	YES	
❒	❒	chills
❒	❒	fever
❒	❒	lack of energy
❒	❒	weight loss

RESPIRATORY

❒	❒	short of breath
❒	❒	frequent cough
❒	❒	wheezing

CARDIOVASCULAR

❒	❒	chest pain
❒	❒	extremity swelling
❒	❒	palpitations

GASTROINTESTINAL

NO	YES	
❒	❒	abdominal pain
❒	❒	change in bowel habits
❒	❒	constipation
❒	❒	diarrhea
❒	❒	difficulty swallowing
❒	❒	heartburn
❒	❒	vomiting blood
❒	❒	blood in stool
❒	❒	loss of appetite
❒	❒	black stool
❒	❒	nausea
❒	❒	reflux
❒	❒	vomiting

GENITOURINARY

❒	❒	painful urination
❒	❒	blood in urine
❒	❒	urinary frequency
❒	❒	urinary incontinence

REPRODUCTIVE

❒	❒	vaginal discharge

NEUROLOGICAL

NO	YES	
❒	❒	headache
❒	❒	numbness
❒	❒	tremors
❒	❒	sensation of room spinning

PSYCHIATRIC

❒	❒	anxiety
❒	❒	increased stress

INTEGUMENTARY

❒	❒	itching
❒	❒	rash

MUSCULOSKELETAL

NO	YES	
❒	❒	back pain
❒	❒	muscle pain
❒	❒	joint pain

HEMATOLOGIC / LYMPHATIC

❒	❒	easy bleeding
❒	❒	easy bruising
❒	❒	enlarged lymph glands

ADDITIONAL GASTROINTESTINAL

❒	❒	bloating
❒	❒	uncontrolled bowel movements
❒	❒	gas
❒	❒	hemorrhoids
❒	❒	yellow skin
❒	❒	painful swallowing
❒	❒	rectal bleeding

ARBITRATION AGREEMENT

BY SIGNING THIS AGREEMENT YOU ARE WAIVING YOUR STATUTORY RIGHT TO A JURY TRIAL AND YOU ARE AGREEING TO ARBITRATE ALL CLAIMS ARISING OUT OF OR RELATED TO YOUR MEDICAL CARE AND TREATMENT.

The term "Physicians" refers to Drs. Moore and Healey, P.A., Robert C. Moore, M.D., Frank H. Healey, M.D., Francis A. Chrzanowski, Jr., M.D., Heather Bennett Matheson, M.D., and their corporate owners, agents, employees, administrators and licensees, and all affiliates thereof The term "Patient" means _____ and includes any legal representative, family member, agent, executor, guardian, power of attorney or any other person acting for, on behalf of or through Patient.

1. ARBITRATION PROVISIONS

A. Agreement to Arbitrate Claims. The Patient agrees that any and all claims or controversies between Physicians and Patient arising out of or in any way relating to medical services rendered to Patient by Physicians, including disputes regarding interpretation of this agreement, whether arising out of State or Federal law, and whether based upon statutory duties, breach of contract, tort theories or other legal theories shall be submitted to final and binding arbitration. It is understood that any dispute as to medical malpractice, that is, as to whether any medical services rendered to Patient by Physicians were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, as well as any claims for personal injury, loss of consortium, or wrongful death, arising out of or in any way relating to the diagnosis, treatment, or care of the Patient, will be determined by submission to arbitration.

B. Waiver of Right to Jury Trial. Both parties to this agreement, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration. The resolution of claims covered by this agreement will be determined by a neutral panel of arbitrators and not a judge or jury. Each party shall select one arbitrator. These two arbitrators shall select a third arbitrator. The arbitrator's award shall be final and binding without the right of appeal except as may be provided under Florida law.

C. Applicable Law. Except as herein provided, the arbitration shall be conducted and governed by the provisions of the Florida Arbitration Code, Florida Statutes, Section 682.01 et seq. In conducting the arbitration under Florida Statutes, Section 682.01 et seq., all substantive provisions of Florida law governing medical malpractice claims, including but not limited to, Florida's Wrongful Death Act, the standard of care for medical providers, and the applicable statute of limitations shall apply.

D. Presuit Notice/Demand. Prior to commencing any action under this Agreement, Patient must comply with the presuit notice and investigation requirements of Chapter 766, Florida Statutes. Demand for Arbitration shall be made in writing and be submitted to the other party to this agreement via certified mail, return receipt requested. In the event that either party to this agreement refuses to go forward with arbitration, the party compelling arbitration reserves the right to proceed with arbitration as set forth in this Agreement, without the participation of the party opposing arbitration or despite his or her absence at the arbitration hearing.

Over

E. **Venue/Fees and Costs**. The arbitration proceedings shall take place in Duval County, Florida. The arbitrator's fees and costs associated with the arbitration shall be divided equally between the parties. The parties shall bear their own attorney's fees and costs and hereby expressly waive any statutory right to recover attorney fees or costs.

F. **One Proceeding/Binding on All Parties**. All claims based upon the same occurrence, incident, or care shall be arbitrated in one proceeding. It is the intention of the parties that this Agreement bind all parties whose claims may arise out of or relate to treatment or services provided by the provider of medical services, including the Patient, the Patient's estate, any spouse or heirs of the Patient, and any children of the Patient, whether born or unborn, at the time of the occurrence giving rise to the claim. In the case of any pregnant mother, the term "Patient" herein shall mean both the mother and the mother's expected child or children. By signing this Agreement, the parties consent to the participation in this arbitration of any person or entity that would otherwise be a proper additional party in a court action.

2. OTHER PROVISIONS

A. **Entire Agreement**. This agreement constitutes the entire agreement between the parties hereto with respect to the subject matter of this agreement and supersedes any prior understandings, agreements, or representations by or among the parties, written or oral.

B. **Severability**. If any provision of this agreement is declared invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

C. **Alternative Providers**. It is understood by the patient that he or she is not required to use Physicians for colorectal surgery and that there are numerous other physicians in northeast Florida who are qualified to perform colorectal surgery.

D. **Withdrawal**. Each party shall have three (3) business days from the execution of this agreement to cancel the agreement by notifying the other party in writing, by certified mail return receipt requested, of its desire to cancel.

BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND VOLUNTARILY ENTER INTO THIS AGREEMENT AND AGREE TO BE BOUND BY THE ABOVE TERMS AND CONDITIONS.

Drs. Moore and Healey, P.A.

By: _____
Physicians' Representative

Date: _____

Patient

By: _____
Patient **or** Patient's Legal Representative

_____
Description of Legal Authority

Date: _____

HISTORY & PHYSICAL

COLON AND RECTAL ASSOCIATES

Robert C. Moore, M. D. • Frank H. Healey, M. D.,
Francis A. Chrzanowski, Jr., M.D., • Heather Bennett Matheson, M.D.

Welcome to our office. Please completely fill out all the attached forms. These facts will be used to complete your medical record and will be kept confidential.

NAME: _____ AGE: _____
Last *First* *Middle*

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE #: ( ) _____ WORK #: ( ) _____ DATE OF BIRTH: _____

SOCIAL SECURITY #: _____ MARITAL STATUS: S M D W SEP RACE: _____

EMPLOYER: _____

EMPLOYER ADDRESS: _____ ZIP: _____

IF YOUR INSURANCE IS UNDER YOUR SPOUSE-PLEASE COMPLETE THE FOLLOWING

SPOUSES NAME: _____ DATE OF BIRTH: _____

spouses SOCIAL SECURITY #: _____ *(NECESSARY TO FILE CLAIMS)*

spouses EMPLOYER: _____ PHONE #: ( ) _____

EMERGENCY CONTACT: _____ PHONE #: ( ) _____ *(required)*

NEAREST RELATIVE OTHER THAN SPOUSE: _____

ADDRESS: _____ PHONE #: ( ) _____

PRIMARY PHYSICIAN (*Full name required*): _____

ADDRESS (*required*): _____

PHONE #: (*required*): _____

(Copy of insurance card(s) required)

PRIMARY INSURANCE: _____ ID#: _____ GROUP #: _____

SECONDARY INSURANCE: _____ ID#: _____ GROUP #: _____

Signature of Patient: _____

FINANCIAL POLICY

COLON AND RECTAL ASSOCIATES

Robert C. Moore, M. D. • Frank H. Healey, M. D.,
Francis A. Chrzanowski, Jr., M.D., • Heather Bennett Matheson, M.D.

Thank you for choosing our practice for your health care needs. Our primary concern is centered on you, our patients, and that you receive the proper care needed. Our financial policy is a necessary part of assuring the financial resources required to maintain this practice for our patients. Therefore, we ask that you please read the following and sign prior to seeing our physician.

Payments are due at the time services are rendered, unless prior arrangements have been made with our billing department. **Co-payments and deductibles are due at the time services are rendered.** We gladly accept cash, checks and for your convenience, MasterCard/Visa/Discover/American Express credit cards. All returned checks are subject to a $25.00 return check fee.

If you belong to a referral-based HMO/POS/PPO plan, it is your responsibility to obtain a current valid referral from your current primary care physician in order to see our physicians. It is important that you have a valid referral each and every time you arrive for an appointment visit. Some referrals include multiple visits; in addition it may include treatment such as x-rays, lab tests and procedures.

It is important that you understand we view your insurance as a contact between you, your employer and the insurance company, therefore, we cannot become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, etc. **Our services are rendered to you, not your insurance company.**

We currently accept assignment with Medicare, and participate with most managed care plans. **If we do not participate with your insurance we will be happy to see you, however, you may pay a higher out-of-pocket expense for utilizing a non-participating provider.** Also, not all services are a covered benefit. Please be aware of your benefit package with your insurance company. Any charges not paid by your insurance company are solely your responsibility. **We file secondary insurance as a courtesy.** If your secondary insurance fails to remit payment within 60 days, we require you to pay the remaining balance. Please ensure that we have a copy of your most current insurance card on file, and that if any changes occur with your insurance that we are notified immediately.

Patients statements are mailed monthly. Please pay promptly upon receiving your statement. All outstanding balances older than 90 days will be subject to review and forwarded to our collection department where an additional $25.00 collection fee will be added to the account balance and forwarded to our collection agency and then to the Credit Bureau. We understand that temporary financial problems may affect timely payment. We encourage you to contact our billing department to make arrangements.

Again, thank you for choosing our practice for your medical needs.

Patient's signature: _____ Date: _____
By my signature I indicate that I have read this policy, and agree to it's provisions.

DRS. MOORE AND HEALEY, P.A.

Robert C. Moore, M. D. • Frank H. Healey, M. D.,
Francis A. Chrzanowski, Jr., M.D., • Heather Bennett Matheson, M.D.

CONDITIONS OF TREATMENT

_____
Initials

AUTHORIZATION FOR TREATMENT. I hereby consent to and authorize the performing of all technical and therapeutic procedures, which in the judgment of any physician may be considered necessary or advisable for diagnosis or treatment while I am a patient of Drs. Moore and Healey, P.A. (Robert C. Moore, M.D., Frank H. Healey, M.D., or Francis A. Chrzanowski, Jr., M.D., & Heather Bennett Matheson, M.D.) ("Physicians").

_____
Initials

RELEASE OF MEDICAL INFORMATION. Physicians may release information from my records as necessary to process claims, obtain reimbursement or payment from an insurance company, workers' compensation carrier, HMO, or other third party payer or health plan. I further authorize Physicians to furnish information from my medical records pertaining to services rendered by Physicians as requested by a primary physician, other medical care facilities, extended care facilities, hospitals, home health agencies, ancillary service providers, or other health care providers for my continued care and treatment. I understand that if these records should include information relating to any HIV testing for AIDS antibody, drug or alcohol use/abuse and treatment, or psychiatric/psychological evaluations and treatment, disclosure of this information to any third party without specific release is prohibited by state and federal statute. Therefore, I specifically authorize Physicians to release all of my records in order to complete my claims or for my care. I understand that this release is effective from the time of receipt by Physicians and it is revocable by me only in writing.

I also authorize the release of information to Physicians of any medical results and/or records pertinent to my care and condition relating to colon and rectal disease.

_____
Initials

ASSIGNMENT OF BENEFITS. The undersigned authorizes payment of benefits including insurance benefits, otherwise payable with respect to the patient, to Physicians. I understand and agree that I am responsible for any unpaid balances not covered by my insurance policies.

_____
Initials

MEDICARE AUTHORIZATION. I authorize any holder of medical or other information about me to release to the Social Security Administration, the Centers for Medicare & Medicaid Services and its intermediaries or carriers any information needed for this or a related Medicare claim or reimbursement. I request the payment of authorized benefits be made on my behalf to Physicians rendering service during any treatment.

_____
Initials

PAYMENT AGREEMENT. The undersigned jointly and severally agrees to pay for Physicians' services. Any moneys payable by insurance companies assigned to and received by Physicians will be credited to the balance due. The assignment of insurance moneys does not alter the undersigned's obligation to pay, and I understand that the filing of a claim for payment with a medical insurance carrier or other third party payer is not equivalent to payment, but only an accommodation for my benefit. Physicians reserve the right to decline further services to the patient without notice or to accept period installment payments without waiving its rights to demand payment in full. This agreement shall be binding upon my heirs, personal representatives, and successors. I understand that if my account is referred to a collection agency or attorney, I will be required to pay all fees and costs related to collection, including reasonable attorney's fees.

I, CERTIFY THAT I HAVE THOROUGHLY READ THIS FORM, OR HAVE HAD IT READ TO ME AND THAT I AM THE PATIENT, OR THE PATIENT'S DULY AUTHORIZED REPRESENTATIVE TO EXECUTE THE ABOVE AND ACCEPT ITS TERMS/CONTENTS, EXCEPT AS NOTED.

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Date

Limited Authorization for Communications to
Family, Friends or Others Involved in the Patient's Care

Patient Name: _____ Date of Birth: _____

I authorize Drs. Moore and Healey, P.A. (Robert C. Moore, M.D., Frank H. Healey, M.D., Francis A. Chrzanowski, Jr., M.D., & Heather Bennett Matheson, M.D.) to disclose all information about my care and treatment to the following family members, friends, relatives or others who are involved in my treatment and care:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Description of the Information. I understand that the information that may be released to my family members or others listed above may include any information from my medical records.

Purpose of Uses and Disclosures. This information will be used or disclosed for purposes of keeping the patient's family and friends updated as to the patient's condition, treatments, and needs. The information will also be used or disclosed at the patient's request.

Revocation. You may revoke this form by sending a written letter to: Drs. Moore and Healey, P.A., 4910 Beach Boulevard, Jacksonville, Florida 32207. The letter must identify the name shown on the original form. It must also include the date you wish to cancel. Your letter will not affect any actions taken before Drs. Moore and Healey, P.A. received your letter.

You may refuse to sign this form.

You do not have to sign this form to receive services or treatment.

If your information is given to others as allowed in this form, Federal privacy laws may not protect it.

Signature: _____ Date: _____

If this form is signed by someone who is not the patient listed above, provide the signor's name and his or her authority to act for the patient.

Signed By: _____ Authority to Sign on Patient's Behalf: _____

(A copy of this form must be provided to the patient).

4910 Beach Boulevard • Jacksonville, Florida 32207 • 904-399-0667

1617 King Street • Jacksonville, Florida 32204 • 904-384-1348