COLON & RECTAL SPECIALISTS, LTD.

PATIENT REGISTRATION FORM

Patient Information

Last Name _____ Home Address _____

First Name _____ M.I. ____ _____

Date of Birth _____ Age ____ Sex ____ City _____

Social Security No _____ ☐ Declined State _____ Zip _____

Home Phone _____ Mobile Phone _____

Email Address _____ ☐ Declined Marital Status _____

Note: By providing your email address, you consent to be added to our patient portal.

Preferred Contact Method: ☐ Home Phone ☐ Mobile Phone ☐ Work Phone ☐ Snail Mail ☐ Patient Portal

Race _____ ☐ Declined Ethnicity _____ ☐ Declined Language _____ ☐ Declined

Employment Information

Employer Name _____ Address _____

Phone _____ City _____ State _____ Zip _____

Emergency Contact Information

Name _____ Relationship _____

Home Phone _____ Mobile Phone _____

Referral Source

Primary Care Physician _____ Referring Physician _____

New Patient Only – Please place a check mark next to applicable referral source: ☐ Referring Physician Noted Above

☐ Family Member/Friend ☐ Yellow Pages ☐ Newspaper/Magazine ☐ Internet ☐ Other _____

Health Insurance Information

Primary Insurance _____ Mailing Address _____

Policy Identification Number _____ City _____

Policy Group Number _____ State _____ Zip _____

Subscriber's Name _____ Subscriber's Social Security No _____

Subscriber's Date of Birth _____ Subscriber's Employer _____

Patient's Relationship to Subscribe _____

Secondary Insurance _____ Mailing Address _____

Policy Identification Number _____ City _____

Policy Group Number _____ State _____ Zip _____

Subscriber's Name _____ Subscriber's Social Security No _____

Subscriber's Date of Birth _____ Subscriber's Employer _____

Patient's Relationship to Subscribe _____

I authorize direct payment to Colon & Rectal Specialists, Ltd., from the above insurance companies (if any) and any unpaid balance will be paid by me. If payment for services is not made when due, I agree to pay all costs of collection including, but not limited to, attorney fees in the amount of 33 1/3% of the delinquent amount owed. This is a lifetime authorization.

Signature of Patient or Responsible Party _____ Date _____

COLON & RECTAL SPECIALISTS, LTD.

NEW PATIENT MEDICAL AND SURGICAL HISTORY

Date _____ Patient's Name _____ Age _____ Height _____ Weight _____

Pharmacy Information

Name of Pharmacy _____ Telephone Number _____ Fax Number _____
Address _____ City _____ State _____ Zip _____

Present Complaint or Illness _____

Previous Surgical History

	Name / Type of Surgery	Date of Surgery
1.		
2.		
3.		
4.		

Previous Illnesses or Hospitalizations

	Illnesses/Hospitalization	Date of Hospitalization
1.		
2.		
3.		

	Current Medications (include over the counter)	Dosage	Frequency
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

DRUG ALLERGIES _____

Medical History

Diabetes	☐ No	☐ Yes
Hypertension / High Blood Pressure	☐ No	☐ Yes
Congestive Heart Failure	☐ No	☐ Yes
Stroke	☐ No	☐ Yes
Heart Attack	☐ No	☐ Yes

Females Only
Number of Pregnancies _____
Number of Miscarriages _____
Date of Last Menstrual Cycle _____

Social History

Use of Alcohol	Use of Tobacco	Dates >	Start	Stop	Use of Drugs
Never ☐	Never Smoker ☐	Former Smoker			Never ☐
Rarely ☐	Current Every Day Smoker, Packs Per Day				Type / Frequency
Moderate ☐	Current Some Day Smoker, Packs Per Day				
Daily ☐	Heavy Smoker, Pack Per Day				
	Light Smoker, Packs Per Day				

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New Patient Medical and Surgical History
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Family Medical History

	Current Age	Diseases	If Deceased, Cause of Death
Father			
Mother			
Sibling(s)			

Complete System Review

Constitutional Symptoms

Good, General Health		☐ No	☐ Yes
Recent Weight Loss	lbs	☐ No	☐ Yes
Recent Weight Gain	lbs	☐ No	☐ Yes
Fevers		☐ No	☐ Yes
Headaches		☐ No	☐ Yes

Cardiovascular

Chest Pain or Angina	☐ No	☐ Yes
Swelling of Feet or Ankles	☐ No	☐ Yes
Palpitations or Skipped Beats	☐ No	☐ Yes

Neurologic

Convulsions or Seizures	☐ No	☐ Yes
Paralysis	☐ No	☐ Yes
Stroke	☐ No	☐ Yes

Hematologic

Bruising Tendency	☐ No	☐ Yes
Bleeding Gums	☐ No	☐ Yes
Anemia	☐ No	☐ Yes
Easy Bleeding	☐ No	☐ Yes

Psychiatric

Trouble Sleeping	☐ No	☐ Yes
Confused Thoughts	☐ No	☐ Yes
Feeling Depressed	☐ No	☐ Yes

Gastrointestinal

Change in Bowel Movements	☐ No	☐ Yes
Nausea	☐ No	☐ Yes
Vomiting	☐ No	☐ Yes
Frequent Diarrhea	☐ No	☐ Yes
Abdominal Pain	☐ No	☐ Yes
Heartburn	☐ No	☐ Yes
Rectal Bleeding	☐ No	☐ Yes

Genitourinary

Burning or Painful Urination	☐ No	☐ Yes
Difficulty Urinating	☐ No	☐ Yes
Frequent Urination	☐ No	☐ Yes
Change in Color of Urine	☐ No	☐ Yes

Respiratory

Chronic or Frequent Coughs	☐ No	☐ Yes
Shortness of Breath	☐ No	☐ Yes
Asthma or Wheezing	☐ No	☐ Yes

Musculoskeletal

Joint Pains	☐ No	☐ Yes
Painful Swollen Joints	☐ No	☐ Yes
Chronically Sore Muscles	☐ No	☐ Yes

Endocrine

Chronic Fatigue	☐ No	☐ Yes
Heat Intolerance	☐ No	☐ Yes
Cold Intolerance	☐ No	☐ Yes
Dry, Flaky Skin	☐ No	☐ Yes
Sleep Apnea	☐ No	☐ Yes

Signature _____ Date _____

Print Form

Colon & Rectal Specialists

CONSENT, DISCLOSURE AND AUTHORIZATION FORM

Patient Name:_____ **DOB:**_____

As used in this form, the words "I", "me", "my" and similar reference means the patient shoes name appears above, or the parent, legal guardian or other legally responsible person on behalf of the minor or incapacitated patient named above.

General Consent for Examination and Treatment

I hereby consent and authorize Colon and Rectal Specialists, Ltd., and all physicians and ancillary medical personnel of Colon and Rectal Specialists, Ltd., to perform medical examinations and provide routine medical care for all of my visits to Colon and Rectal Specialists, Ltd., including routine diagnostic and laboratory procedures and tests, medication administration, and other routine care for which a specified informed consent form will not be signed by me.

Acknowledgement of Receipt of Notice of Privacy Practices

I have read and understand Colon and Rectal Specialists, Ltd., HIPAA Notice of Privacy Practices, which contains information on the uses and disclosures of my protected health information ("PHI"). I understand that I may also access a copy on the company's website at www.crspecialists.com.

Consent to Use and Disclose Protected Health Information for Treatment, Payment and Health Care Operations

I hereby consent and authorize Colon and Rectal Specialists, Ltd., to use and disclose my health information, which includes all or any part of my medical record, by and to its workforce members, and to health care professionals, insurance companies, medical facilities, physicians and vendors, or suppliers involved, or who may become involved, with my treatment, the payment for my treatments and/or the health care operations of Colon and Rectal Specialists, Ltd. I understand that for example, my health information may be used or disclosed by Colon and Rectal Specialists, Ltd., to: provide for my care and treatment; communicate among various health care professionals who are involved in my care or treatment; bill for or obtain payment for care and treatment provided by Colon and Rectal Specialists, Ltd.; provide information to and obtain payment from my health insurance company or plan; assess and review the quality of my care; and conduct its business in health care operations. In addition, I understand that Colon and Rectal Specialists, Ltd., may release my protected health insurance as required by law or court order.

Practice Policy for Administrative Services

I acknowledge that I have received, reviewed, understand and will comply with the following policies:

1. All checks returned for insufficient funds or a closed account will incur a $25 fee.
2. To obtain a copy of your medical records, you will be required to sign a Medical Release Form that is found on our website at www.crspecialists.com and return the form via fax to 804-249-2461. There is a processing fee of $10 plus $0.50 per page. These fees, set forth by Virginia State Law, must be paid in full before you request can be processed.
3. We can complete any forms such as FMLA or Disability by faxing them to 804-249-2461. The fee to complete these forms is $20 per form and must be paid in advance. Please allow 7-10 days for completion.

4. Surgical or Endoscopy procedures cancelled with less than three (3) business days notice will incur a fee of $100. For example, procedures scheduled on Monday have to be rescheduled or cancelled by calling our office at 804-249-2465 by the preceding Wednesday.

Notice of Deemed Consent

A law enacted in Virginia in 1989 authorizes health care providers to test their patients for HIV, Hepatitis B, and Hepatitis C antibodies when the health care provider is exposed to bodily fluids in a manner which they may, according to certain medical authority, transmit Human Immunodeficiency Disorder (HIV), the virus that causes Acquired Immunodeficiency Syndrome (AIDS) and related disorders, Hepatitis B or Hepatitis C viruses. Pursuant to this law, in the event of such an exposure, you will be deemed to have consented to such testing, and to have consented to the release of the test results to the health care provider who may have been exposed. However, if such exposure occurs, you will be informed before any of your blood is tested for HIV, HEP B or HEP C antibodies pursuant to this provision, the testing will be explained to you, and you will be give the opportunity to ask any questions you might have.

The law also provides that if you should be exposed to the bodily fluids of a health care provider in a manner which may, according to certain medical authority, transmit HIV, HEP B or HEP C, the health care provider is deemed to consent to such testing and to the release of the test results to you.

Prescription Information

Your physician may write you a prescription for a custom medication specific to your condition that is not commercially available. Therefore, it is not covered under insurance. You may either pick the prescription up at a designated RX3 pharmacy or have it delivered to your home. If you are a candidate for this type of medication, your physician will discuss it with you during your visit.

For all other commercial medication, we use E-Prescribe to the pharmacy of your choice. E- Prescriptions are computer generate prescriptions created by your provider and sent directly to your pharmacy through a HIPAA (Health Insurance Portability and Accountability Act) secure connection. The e-prescription is much faster and may save you time because you do not have to come into the office to pick up your written prescription. By signing this form you agree that Colon and Rectal, Ltd. may use e-prescribe and may request and use your prescription medication history from other health care providers or third-party pharmacy benefits payers for treatment purposes. This consent will remain in effect until the day that you revoke it. You may revoke this consent at any time in writing, but if you do, it will not have any effect on any actions taken prior to revoking the consent.

☐ Please use e-prescribe

☐ Please do not use e-prescribe. I want to come to the office and pick up a written prescription

Disclosure to Authorized Individuals

I understand that Colon and Rectal Specialists, Ltd., may release PHI to a family member, friend, or other person I indicate is involved in my care unless I object. I designate the following person (s) listed below as a person(s) involved with my health care and/or payment for my health care (circle as applicable(, to whom the information circled "yes" below may be released:

Name:_____ Relationship:_____
Address/Phone:_____
_____
Health Info: Yes/No (circle as applicable) Payment Info Yes/No (circle as applicable)

List any health topics/information you do not want us to share with the above individual:
_____

Name:_____ Relationship:_____
Address/Phone:_____
_____
Health Info: Yes/No (circle as applicable) Payment Info Yes/No (circle as applicable)

SIGNED CONSENT AND AUTHORIZATION

I have read and understand the terms of this document. I had had an opportunity to ask questions about the use and disclosure of my health information and about the contents of this form. I acknowledge, consent and agree to the terms and conditions of this document:

Patient Name:_____ Date:_____

Patient Signature:_____

Authorized Individual (Parent/Guardian) Name _____

Authorized Individual Signature _____

Relationship to Patient:_____

Colon & Rectal Specialists, Ltd.

PATIENT RIGHTS AND RESPONSIBILITIES

As a patient of our practice we consider you (the patient) an important partner in your healthcare. When you are well informed, participate in decisions, and communicate openly with your physician and other health professionals, you help make your care as effective as possible.

PATIENT RIGHTS

- To be informed of your patient rights in advance of care being provided or discontinued
- To participate in and make informed decisions about your care including being able to request or refuse treatment, except when such participation is contraindicated for medical reasons
- To change your provider: There are a number of Board Certified Colon and Rectal Surgeons who have a wide variety of practice styles to meet the expectations of all our patients
- To have your condition, treatment, and outcomes explained in a manner that you understand and to interpretation services if needed or requested
- To be provided, to a degree known, complete information concerning your diagnosis, evaluation, treatment and prognosis. When it is medically inadvisable to provide you such information, the information will be provided to a person designated by you or to a legally authorized person
- To receive safe, high quality, medical care, without discrimination, that is compassionate and respects personal dignity, values, beliefs and preferences
- To be treated without fear of or infliction of mistreatment, neglect, verbal, physical, mental or sexual abuse
- To know the name and role of your providers (e.g., physician, CRNA, nurse, etc.) and to request credentials on the physician providing your care
- To be fully informed of the scope of services available, provisions for after-hours emergency care, and related fees for services rendered along with available payment options
- To be informed of any investigational, research, or educational activities related to your care; to refuse to participate in any such activity; and to review that decision periodically
- To every consideration of privacy concerning your medical care: Case discussion, consultation, examination, and treatment are confidential and will be conducted discreetly.
- To have your Protected Health Information (PHI) treated confidentially
- To be given the opportunity to approve or refuse the release of your PHI, except when release is required by law. You are entitled not to share your PHI with your provider upon request if you are paying for service out of pocket.
- Advance Directives
  - To have an Advance Directive (living will and/or durable power of attorney for health care decisions)
  - To obtain information regarding an Advance Directive
  - To have your Advance Directive (if you have one) included in your medical record
  - To have your Advance Directive followed to the extent that is medically appropriate and lawful
- To have your compliments, concerns, complaints, or grievances addressed. Sharing your concern and/or complaints will not compromise your access to care, treatment and services. You may contact the Practice Administrator, 8700 Stony Point Pkwy, Suite 270, Richmond, VA 23235 or 804.249.2465 or Virginia Center for Quality Health Care Services, 3600 West Broad Street, Suite 216, Richmond, VA 23220 or 800.955.1819.

PATIENT RESPONSIBILITIES

- To be respectful of all health care professionals and staff, as well as other patients
- To provide, to the best of your knowledge, accurate and complete information about your health, present complaints, past illnesses, hospitalizations, medications including over-the-counter and dietary supplements; allergies, sensitivities and insurance benefits
- To ask for more information if you have questions about your care, treatment, services or health care professionals
- To report perceived risks in your care and unexpected changes in your condition
- To ask your care provider when you do not understand medical words or instructions about your plan of care. If you are unable/unwilling to follow the plan of care, you are responsible for telling your care provider. Your care provider will explain the medical consequences of not following the recommended treatment. You are responsible for the outcome of not following your plan of care.
- To abide by our office rules and regulations and practice fee policy by providing appropriate notification when there exists a need to change or cancel your procedure
- To have a responsible adult to drive you home after your procedure and remain with you for 24 hours following your procedure: Your procedure will be cancelled if you do not have a driver.
- To inform your provider about any living will, power of attorney, or other directive that could affect your care
- To tell us how satisfied you are with your care, so that we can resolve your concerns and learn from them
- To accept the financial obligations incurred in your healthcare and fulfill such obligations promptly