Gastroenterology of Greater Orlando

Vishal Gupta M.D.
Christina Covelli M.D.
Jignesh Patel M.D.
Board Certified in Gastroenterology

Patient Check in Form

Date of Birth (m/d/y)_____Today's Date_____

Last Name_____First Name_____Middle Initial_____

Street Address_____
City_____State_____Zip Code_____
Email Address_____
Home Phone ( )_____Cell Phone ( )_____
Work Phone ( )_____Other Phone ( )_____
Gender M F Social Security #___/___/____
Marital Status Married Single Widowed Divorced

Who referred you to our practice?_____
Primary Care Physician____:_____
Emergency Contact: Name_____Phone # ( )_____
Address_____Relationship_____
Primary Insurance Name/Company: _____
Do you have a secondary insurance? (Yes) or (No) If yes name of insurance:_____

Person who is responsible for insurance account (person who holds the insurance policy or legal Guardian of a minor)

Last Name_____First Name_____Middle Initial___
Home Phone ( )_____Work Phone ( )_____Ext._____
Relationship to patient_____ Social Security#_____
Date of Birth (m/d/y)_____Gender M F
Employer _____Occupation_____

2728 Enterprise Road, Suite 100
Orange City, FL 32763
Phone 386-668-2221

1319 S International Pkwy, Ste 1171
Lake Mary, FL 32746
Phone 407-749-6656

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Name: _____ Date_____
Primary Care Physician:_____
Chief of Complaint: _____
_____

Current Medications and Dosages
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Allergies to Medications
_____
_____

Social History
Have you ever smoked? __Yes __No
Do you currently smoke? __Yes __No
If yes, How much? _____
Do you drink alcohol __ Yes __No
If yes, How much? _____
Any history of illicit Drugs? _____

Family History (Check if Applies)
___ Heart Disease ____ Colon Cancer
___ Diabetes ____ Colon Polyps
___ High Blood Pres. ____ Stroke
___ Crohns Disease/ Ulcerative Colitis
___ Other_____
Past Medical History (Check if Applies)

___High Blood Pressure
___Strokes
___Diabetes
___High Cholesterol
___Heart Disease
Details:_____
___Angina
___Congestive Heart Failure
___Emphysema/Smokers Lung
___Asthma
___Prostate Problems
If yes, Prostate Cancer_____ or ___Enlarged Prostate
___Thyroid Problems
If yes, Hypothyroidism____ or
_____Hyperthyroidism
___Seizures
___Cancer
___Depression
___Arthritis
___Other_____
Past Surgical History
____ Heart Catheterization
____ Open Heart Surgery
____ Appendix Surgery
____ Gallbladder Surgery
____ Other Surgeries:_____
_____

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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 Gastroenterology of Greater Orlando.

Authorization for Release of Confidential Information: I hereby authorize Gastroenterology of Great Orlando 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 received 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 initiated 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 Gastroenterology of Greater Orlando, 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 Gastroenterology of Greater Orlando 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 Gastroenterology of Greater Orlando 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 Gastroenterology of Greater Orlando is not the business of extending credit. Therefore, it is the policy of Gastroenterology of Greater Orlando 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 Gastroenterology of Greater Orlando, regardless of my insurance benefits. I authorize a copy of this form to be valid as the original.

Patient/Responsible Party:_____ Date:_____

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PATIENT PORTAL AUTHORIZATION FORM

Our patient portal lets established patients communicate more easily with us. The portal is not intended for "Web Visits" or new problems. Instead, it will make regular communication more flexible. The portal is a voluntary option and is free of charge to all patients. The patient portal provides you with a much more seamless way to access your health information and contact our office.
Through the portal, you can:

- Request refills
- Update your contact and insurance information
- Check your medication list, medical history and your visits
- Get your lab results quickly
- Email us securely back and forth

We want your records to be complete and correct. Let us know if there's any problem with your records. Sometimes we may use medical jargon in your records and it can lead to confusion, if something doesn't make sense, let us know.

Privacy matters. We will never sell/trade/abuse your email address. The patient portal is protected just like all other interactions with our office. We also think it's important for you to protect privacy on your end, and we recommend that you protect your user name and password to avoid misuse.

We take security seriously, too. Computer networks do have real risks. We use appropriate technologies to protect your health information. We follow all security laws, including HIPAA and HITECH.

Bedside manner is complicated via email. It's easy to misread information or emotion. We'll try to keep things brief and clear on the Portal. We really appreciate your help on that, too. If a message takes a long time to write, it's probably something better done in person at an office visit.

If we have troubles, abuse or 'Spam', we may need to change policies, suspend accounts, or even terminate the portal.

You can access the portal day or night, but we don't have a 24 hour presence on our end. As a safeguard, the portal should not be used for pressing issues. If you are experiencing an emergency or have an urgent medical need, you should call our office. If it's after hours, we recommend that you go to Urgent Care, the emergency room or call 911.

By signing below, I understand there are pros and cons to using the patient portal for communications with the clinic. I have had a chance to discuss my concerns with the office and have my questions answered.

By signing below, I acknowledge that I would like a Patient Portal account and agree to the terms and conditions set forth above.

Signature:_____ Print Name:_____
E-mail address_____

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ADVANCE CARE PLAN

(Patients aged > 65 years)

Name: _____

Address: _____

Date of Birth: _____

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):

_____

_____

_____

Signature _____

Printed Name: _____

Date: _____

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