



**Gastroenterology
of Greater Orlando**

**Vishal Gupta M.D.
Ashil Gosalia M.D.
Vernu Visvalingam M.D.
Karl Mersich M.D.
Kaleem Ahmed M.D.**

Board Certified in Gastroenterology

NEW PATIENT REGISTRATION FORM

Last Name		First Name		MI	
Date of Birth (mm/dd/yyyy)			Today's Date		
Address					
City		State		Zip	
Email					
Home Phone			Cell Phone		
Work Phone			Other Phone		
Gender	M / F / Trans / Other	Social Security #		Marital Status	Married / Single / Widowed / Divorced
Who referred you to our practice?					
Primary Care Physician					

EMERGENCY CONTACT

Name		Phone #		Relationship	
Address					

INSURANCE INFORMATION

Primary Insurance Company		Secondary Insurance			
Person who is responsible for Insurance Account <i>(Person who holds the insurance policy or legal guardian of a minor. If you are the holder, you may skip this part)</i>					
Last Name		First Name		MI	
Home Phone			Cell Phone		
Work Phone			Other Phone		
Relationship to Patient			Social Security #		
Date of Birth (mm/dd/yyyy)			Gender	Male / Female / Trans / Other	
Employer			Occupation		

Name				Date			
Reason for Visit							
Current Medications				Past Medical History (check all that apply)			
				High Blood Pressure			
				Strokes			
				Diabetes			
				High Cholesterol			
				Heart Disease → Details:			
Allergies to Medications				Angina			
				Congestive Heart Failure			
				Emphysema / Smoker's Lung			
				Asthma			
Social History				Prostate Problems → Cancer / Enlarged			
Have you ever smoked?	Y	N		Thyroid Problems → Hypothyroidism / Hyperthyroidism			
Do you currently smoke?	Y	N		Seizures			
If yes how much? →				Cancer			
Do you drink alcohol?	Y	N		Depression			
If yes, how much? →				Arthritis			
Any history of Illicit Drugs?	Y	N		Kidney Disease			
Family History (check all that apply)				Other → Details:			
Heart Disease		Colon Cancer		Past Surgical History (check all that apply)			
Diabetes		Colon Polyps		Heart Catheterization			
High Blood Pressure		Crohn's Disease		Open Heart Surgery			
Stroke		Ulcerative Colitis		Appendix Surgery			
Other →				Gallbladder Surgery			
Colonoscopy				Other Surgeries → Details:			
Year of Latest Colonoscopy							
Year of Latest Upper Endoscopy EGD							



Vishal Gupta M.D.
Ashil Gosalia M.D.
Vernu Visvalingam M.D.
Karl Mersich M.D.
Kaleem Ahmed M.D.
Board Certified in Gastroenterology

Advanced Care Plan
(Patients Aged 65 Years or Older)

Name	
Address	
Date of Birth (mm/dd/yyyy)	

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):

Name	Phone Number

Signature _____

Printed Name _____

Date _____



Vishal Gupta M.D.
Ashil Gosalia M.D.
Vernu Visvalingam M.D.
Karl Mersich M.D.
Kaleem Ahmed M.D.
Board Certified in Gastroenterology

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 eived 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 initialed 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: _____

Cancellation/No Show Policy for Provider Appointments and Procedures

We understand that there are times when you must miss an appointment or procedure due to emergencies or obligations for work or family. However, when you do not call to cancel, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly “full” schedule.

1. *Cancellation/ No Show Policy for Provider Appointment*

If an appointment is not cancelled at least 5 days in advance you will be charged a twenty dollar (\$20) fee; this will not be covered by your insurance company!

2. *Late Arrival for Office Appointments*

We understand that delays can happen however we must try to keep the other patients and doctors on time.

If a patient is greater than 15 minutes past their scheduled time we will have to reschedule the appointment.

3. *Cancellation/ No Show Policy for Procedures*

In order to provide the most efficient scheduling to our patients, we need to keep appointment cancellation and “no show” activity to a minimum. To accomplish this a cancellation and “no-show fee will be charged to the patient if procedures are canceled without proper advance notice, or if the patient does not show up for a scheduled procedure.

If procedures are not cancelled at least 5 days in advance you will be charged:

- **Colonoscopy and / or Endoscopy will be \$200**
- **Capsule Endoscopy will be \$100**
- **Anal Manometry will be \$100**
- **Hemorrhoid Treatments will be \$20**

As a courtesy, we make every effort to remind patients of their office visit by telephone 3-4 business days before the appointment date. These are not calls to confirm the appointment, but are calls to remind the patient of their appointment. It is your responsibility to provide us with the appropriate advance notice if you need to cancel an office visit. Cancellations can be made at ANY time by calling 386-668-2221 and leave a message if necessary.

This fee will not be covered by your insurance company!

Print Name

Patient Signature/Guardian

____/____/____
Date