Dear Valued Patient:

Thank you for choosing GastroMD as your gastroenterology provider. As a trusted provider for all gastroenterology health needs, we strive to exceed your expectations.

Please complete the following forms to the best of your ability. If you have questions or need assistance, please let us know. Bring these completed forms with you to your appointment, along with:

- a photo ID,
- insurance card(s), and
- copay or any other patient responsibility due.

Important: If you do not have your ID, insurance card, or patient responsibility upon arriving for your appointment, you will be rescheduled.

To maintain an efficient and timely visit, please arrive at least 15 minutes before your scheduled appointment time to allow time to process your paperwork.

To the extent possible and feasible, all patient financial responsibilities are payable at the time of service.

Thank you, and we look forward to seeing you at your scheduled time.

PATIENT INTERVIEW FORM

PATIENT INFORMATION

First Name:_____ Last Name: _____ MI: _____

Date of Birth: _____ Pharmacy & Location :_____

Address: _____ Apt: _____ City: _____ State: _____ Zip: _____

Preferred Phone Number: _____ Alternate Phone Number: _____

Email Address: _____

Referring Provider: _____ Primary Care: _____

Race

☐ White/Caucasian ☐ Black or African American ☐ Asian ☐ Hispanic or Latino ☐ American Indian or Alaska Native

☐ Native Hawaiian or Other Pacific Islander ☐ Mixed ☐ Other ☐ Unknown ☐ Patient declines to provide information

Ethnicity

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Patient declines to provide information

Gender

☐ Male ☐ Female ☐ Other

Preferred Language

☐ English ☐ French ☐ Portuguese ☐ Spanish ☐ Creole ☐ Other: _____

COMMUNICATIONS

I authorize GastroMD to contact me at the email address and phone numbers above: ☐Yes ☐No

Persons to whom we may release information (Please select what type of information we may discuss with them by initialing as applicable.

I authorize GastroMD to share Patient **Medical**____ **Billing**____ information with the following individuals:

Name:_____Relationship to patient:_____

Name:_____Relationship to patient:_____

Name		Date	
Reason for Visit			

Current Medications				**Past Medical History (check all that apply)**			
				☐	High Blood Pressure	☐	GERD/ Heartburn
				☐	Stroke	☐	Diverticulosis
				☐	Diabetes	☐	Hemorrhoids
				☐	High Cholesterol	☐	Colon Polyps
				☐	Congestive Heart Failure	☐	Fatty Liver
				☐	Emphysema / COPD	☐	Hepatitis
Medication Allergies				☐	Asthma	☐	Anemia
				☐	Depression	☐	Others:
				☐	Seizures		
Social History				☐	Kidney Disease		
Have you ever smoked?	Y		N	☐	Angina		
Do you currently smoke?	Y		N	☐	Dialysis		
If yes, how much?				☐	Heart Disease→Details:		
Do you drink alcohol?	Y		N	☐	Prostate Problems→ Cancer / Enlarged		
If yes, how much?				☐	Thyroid Problems→ Hypothyroidism / Hyperthyroidism		
Any history of Illicit Drugs?	Y		N	☐	Arthritis: Osteoarthritis or Rheumatoid		
Family History (check all that apply)				☐	Cancer→ Type:		
☐ ←Heart Disease		☐	←Colon Cancer	**Past Surgical History (check all that apply)**			
☐ ←Diabetes		☐	←Colon Polyps	☐	Heart Catheterization		
☐ ←Hypertension		☐	←Crohn's Disease	☐	Open Heart Surgery		
☐ ←Stroke		☐	←Ulcerative Colitis	☐	Appendix Surgery		
☐ Other:				☐	Gallbladder Surgery		
Colonoscopy/ EGD History				☐	Other Surgeries → Details:		
Year of Latest Colonoscopy							
Year of Latest Upper Endoscopy EGD							

FINANCIAL POLICY AND FINANCIAL CONSENT

Below are the Financial Policies of Gastro MD Florida, LLC, and its affiliated and subsidiary entities. All references of policies throughout this document shall apply equally to all of Gastro MD Florida, LLC's affiliated and subsidiary entities, its physicians and services, which will be referred to herein collectively as "GastroMD", "we", "us" or "our".

INSURANCE INFORMATION

Your health insurance is a contract between you and your insurer. Any charges not paid by your insurer for any reason are your responsibility. It is your responsibility to understand your insurance benefits, including plan limitations, the difference between screening or preventative care benefits versus diagnostic procedure benefits and the need for referrals or pre-authorizations. We will make every effort to verify your benefits, and identify your financial responsibility and pre-authorization requirements prior to your appointment on your behalf; however, this is not a guarantee of payment as your health insurance will determine payment after they receive a claim from us. It is your responsibility to inform us of any changes to your insurance policy so that your coverage can be re-verified prior to your appointment. You hereby authorize GastroMD to furnish and/or release any information necessary to your insurance carrier(s) concerning your illness and treatments. We will bill your insurance for all services we provide; however, we require you to pay any portion of your financial responsibility for care, including, but not limited to, co-pays, deductibles, and/or co-insurance, prior to the service. Certain services performed by our office, for your benefit, may not be covered by your insurance plan(s). GastroMD recommends you contact your insurance carrier to verify your benefits and understand any non-covered services as these will be your financial responsibility. Please note if you obtain a policy from the Affordable Care Act marketplace, and are issued a subsidy, but fail to pay your premium during the grace period, your care will be entirely your financial responsibility. You hereby assign to GastroMD, the physician(s) or other healthcare provider(s) all payments for medical or healthcare services rendered to you or your dependents, and you authorize your insurance carrier(s) to issue payment directly to GastroMD for the medical and healthcare services rendered to you and/or your dependents regardless of your insurance benefits, if any. CERTAIN INSURANCE CARRIERS OR EMPLOYERS MAY HAVE A NARROW NETWORK THAT EXCLUDES YOUR PHYSICIAN OR HEALTHCARE PROVIDER. IF OUR SERVICES ARE DEEMED OUT OF NETWORK AND YOUR BENEFIT PLAN HAS NO OUT OF NETWORK BENEFITS, IT IS THE PATIENT'S RESPONSIBILITY TO PAY FOR THE SERVICES IN FULL. PLEASE CONSULT WITH YOUR PLAN IN ADVANCE OF YOUR VISIT.

ADMINISTRATIVE FEES

As a courtesy to other patients who are waiting for appointments, we require that you provide us with notice of any cancellation of an appointment. Missed or cancelled appointments are subject to the following fees, which are not covered by your insurance:

Surgical Center or Hospital Procedure with less than 72 hours' notice	**$75**
In-office Procedure with less than 24 hours' notice	**$50**
Office Visit with less than 24 hours' notice	**$25**

In addition, missed or cancelled appointments without required notice may result in a fee charged by the applicable Surgical Center, Hospital or other facility. There is a charge for returned checks for any reason (check with your office's staff for specific fees charged). Failure to remedy the returned check may result in legal action. Additionally, there may be a fee charged for completing forms (check with your office's staff for specific fees charged) and copying medical records in accordance with state laws.

GASTROMD CARD ON FILE POLICY

GastroMD is committed to reducing waste and inefficiency and making our billing process as simple as possible. We require that you provide a credit card on file with our office. We run payments through a secure, HIPAA and PCI- compliant merchant services application. The security of your private information is our priority. For your protection, only the first digit and last four digits of your card will show in the system.

Credit Cards on File will be used to pay account balances after insurance adjudication.

1) Once your insurance has processed your claim, they will send an Explanation of Benefits (EOB) to both you and our office showing your total patient financial responsibility. You typically receive the EOB before we do, so if you disagree with the patient responsibility amount owed, it is your responsibility to contact your insurance carrier and our office immediately.

2) When we receive the EOB, we will enter this information in our system. We will send you a statement showing the patient responsibility amount owed. You will have twenty-one (21) days from the date of the patient statement to pay the amount due. If the patient responsibility owed is not paid within twenty-one (21) days of the statement date, your credit card on file will be processed by GastroMD. If your total amount owed is $450 or less, we will process a payment for the total amount owed, as shown on your statement, up to $450, to your credit card on file. If your total amount owed is greater than $450, we will process a payment in the amount of $450 to your credit card on file, and you will receive additional patient statements for the remaining balance.

Your credit card is processed only after your insurance has processed your claim. Your ability to dispute your insurance company's charges will not be compromised.

Credit Cards on File will also be used to pay any administrative fees that remain unpaid, and these fees are not covered by your insurance.

OPEN BALANCES

You may have outstanding balances for more than one location of GastroMD. We reserve the right to collect on balances for any affiliated or subsidiary entities of GastroMD. You understand that if you fail to adhere to our financial policies you may be sent to a third party collection agency, and you agree to be responsible for all collection costs and fees incurred by GastroMD including, but not limited to, all reasonable collection fees or reasonable contingency fees added by a third party to the outstanding or referred balance.

CONSENT TO RECEIVE TEXT MESSAGES FROM GASTROMD

I give GastroMD and its staff and patient notification service permission to contact me via my cellular device for automated phone calls and SMS text messages. I understand that emergency notifications are excluded from this permission and will be sent as normal. I understand that message/data rates may apply to messages sent through GastroMD to my mobile phone. I understand that I am under no obligation to authorize GastroMD to send text messages as part of this program. By signing, I certify that I am the owner of this cellular device and its user contract.

By signing below, I confirm that I have read and understand the Financial Policies of GastroMD above and agree to and accept all the Financial Policies, including, but not limited to, the credit card on file policy. I authorize GastroMD to use my credit card on file to pay all administrative fees and/or outstanding balances but only after my insurance has been processed and not more than twelve (12) months after my credit card has been placed on file. I give GastroMD permission to apply payments to any administrative fees or outstanding balances amongst its locations. I understand that I am ultimately financially responsible for the services I receive from GastroMD. Should I neglect to meet my financial responsibility, I understand that I may be charged additional fees incurred in the collection process, including from third party collection agencies.

SIGNATURE X _____ _____

Signature of Individual or Individual's Legally Authorized Representative — DATE

Printed Name of Legally Authorized Representative (if applicable): _____

If representative, specify relationship to the individual: ☐ Parent of Minor ☐ Guardian ☐ Other _____

SIGNATURE X _____ _____

Signature of Minor Individual — DATE

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION? May we disclose your protected health information to your: spouse, adult children, siblings, attorney, Life Insurance Company or other entity? If yes, please write their name, contact information and relationship to you.

Person/Organization Name_____
Relationship_____
Address_____
City_____State_____Zip Code _____
Phone (_____)_____Fax (_____)_____

Person/Organization Name_____
Relationship_____
Address_____
City_____State_____Zip Code _____
Phone (_____)_____Fax (_____)_____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- ☐ **All Health Information**
- ☐ History/Physical Exam
- ☐ Past/Present Medications
- ☐ Lab Results
- ☐ Physician's Orders
- ☐ Patient Allergies
- ☐ Operative Reports
- ☐ Consultation Reports
- ☐ Progress Notes
- ☐ Discharge Summary
- ☐ Diagnostic Test Reports
- ☐ Pathology Reports
- ☐ Billing Information
- ☐ Radiology Reports
- ☐ Imaging Films
- ☐ Other _____

Your initials are required to release the following information:

_____ Mental Health Records (Excluding psychotherapy notes) _____Genetic Information (Including Genetic Test Results)

_____ Drug, Alcohol, or Substance Abuse Records _____HIV/AIDS Test Results/Treatment

_____ Sexually Transmitted Diseases (STD/STI) Tests or Treatment

EFFECTIVE TIME PERIOD: This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional):

Month_____Day_____Year_____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected. If I revoke this Authorization, I must send a written request to: **GASTROMD FLORIDA, LLC 511 W Bay St, STE 400, Tampa, FL ATTN: Privacy Officer**. I understand that the revocation will not apply to information that has already been released in reliance on this Authorization and to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

MOBILE PHONE COMMUNICATION CONSENT: By signing this document, you consent to your mobile phone number to be used to communicate with you by text or voice through an automated or pre-recorded message to provide you with information related to your healthcare, account or bills for healthcare services, and information related to additional healthcare services that may be of interest to you. You are not required to provide us with your mobile phone number for these purposes.

If you have not provided GastroMD with your mobile phone number, you may provide it here: (_____) _____-_____.
SIGNATURE AUTHORIZATION: I have read this form and agree to the use and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X _____ _____
Signature of Individual or Individual's Legally Authorized Representative DATE

Printed Name of Legally Authorized Representative (if applicable): _____

If representative, specify relationship to the individual: ☐ Parent of Minor ☐ Guardian ☐ Other_____

SIGNATURE X _____ _____
Signature of Minor Individual DATE

PATIENT INFORMED CONSENT FOR TREATMENT AND NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

PELVIC/RECTAL EXAMINATION INFORMED CONSENT: The undersigned understands that the physical examination may include a medically appropriate examination of his/her pelvic area, and/or rectum and he/she consents to such examination.

GENERAL TREATMENT CONSENT: The undersigned has voluntarily presented for medical care and consents to such medical care andtreatment including any diagnostic procedures and tests that the physician(s), his or her associates, assistants and other healthcare providers determine to be necessary or appropriate for the purpose of diagnosis. Procedures or exams may include, but are not limited to anoscopy, breath tests, capsule endoscopy, fibroscan, hemorrhoid banding, ultrasound, and rectal exam. The undersigned understands that the natureof, intended purpose, potential risks/complications, and alternatives for each procedure or treatment will be explained to him/her beforehand. The undersigned understands and acknowledges that no warranty or guaranty has been or will be made as to the result or cure of treatment.

NOTICE OF PRIVACY PRACTICES ACKOWLEDGEMENT: The undersigned understands he/she has a right to review the GastroMD's Notice of Privacy Practices prior to signing this document and acknowledges that the GastroMD's Notice of Privacy Practices has been made available to him/her. The Notice of Privacy Practices for the GastroMD is also provided in the waiting room.

SIGNATURE X _____ _____
Signature of Individual or Individual's Legally Authorized Representative DATE

Printed Name of Legally Authorized Representative (if applicable): _____

If representative, specify relationship to the individual: ☐ Parent of Minor ☐ Guardian ☐ Other_____

SIGNATURE X _____ _____
Signature of Minor Individual DATE