Valerie R. Dyke, MD, FACS, FASCRS
Janette U. Gaw, MD, FACS, FASCRS
Nagesh B. Ravipati, MD, FACS, FASCRS
Jeffrey A. Neale, MD, FACS, FASCRS
Fia Yi, MD, FACS, FASCRS
Colorectal Surgery

The Colorectal Institute
Telephone: 239.275.0728 · Fax: 239.275.6947

Colorectal Cancer Awareness

PLEASE PRINT CLEARLY: **Date:** _____

NAME: _____ SSN: _____

SEX: ❑MALE ❑FEMALE AGE: _____ BIRTH DATE: _____

MARITAL STATUS: ❑S ❑M ❑W ❑D SPOUSE/PARTNER'S NAME: _____

HOME PHONE: _____ CELL PHONE _____

ALTERNATE CONTACT- NAME(S)/NUMBER(S): _____

LOCAL ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

OUT OF STATE ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PATIENT'S EMPLOYER: _____

WORK PHONE: _____ YEARS EMPLOYED: _____

OCCUPATION: _____

PREFERRED PHARMACY: _____
Pharmacy Name *Location* *Phone*

INSURANCE INFORMATION

PLEASE PRESENT ALL INSURANCE CARD(S) FOR OUR RECORDS

PRIMARY INSURANCE: _____

SECONDARY INSURANCE: _____

REFFERING DOCTOR: _____ PHONE: _____

IF INSURED IS SOMEONE OTHER THAN THE PATIENT

INSURED'S NAME: _____ BIRTHDATE: _____

SSN: _____ RELATIONSHIP TO PATIENT: _____

WE ARE DEDICATED TO PROVIDING THE BEST CARE POSSIBLE TO OUR PATIENTS. WE CAN BETTER ACCOMPLISH THIS GOAL BY OBTAINING YOUR OPINION ON HOW WE ARE DOING. MAY WE CONTACT YOU BY MAIL, E-MAIL, TEXT, OR TELEPHONE FOR OUR SURVEY?

_☐_ YES _☐_ NO

Welcome to The Colorectal Institute

Valerie R. Dyke, MD Janette U. Gaw, MD Nagesh B. Ravipati, MD Jeffrey A. Neale, MD Fia Yi, MD

Date: _____

Patient Name:_____ ❑Male ❑Female Age:_____

Referring Physician: _____Primary Care Physician: _____

If not referred, how did you hear about us? _____

Reason for Visit: _____

ALLERGIES: _____

_____

ROS: Check if you **currently have or recently** have had:

❑ chills	❑ nosebleeds	❑ pain after eating	❑ headaches
❑ fevers	❑ cough	❑ gastritis	❑ joint pain
❑ weight loss	❑ coughing up blood	❑ difficulty swallowing	❑ muscle pain
❑ hearing loss	❑ palpitations	❑ skin dryness	❑ bone pain
❑ nosebleeds	❑ severe leg pain	❑ rashes	❑ excessive bleeding
❑ mouth sores	❑ chest pain	❑ change in skin color	❑ bruising
❑ lump / swelling in neck	❑ blood in urine	❑ dizziness	❑ swollen glands
❑ shortness of breath	❑ burning with urination	❑ seizures	

Previous Tests	**Doctor/Location**	**Date**	**Results**

Upper Endoscopy (EGD)_____

*Colonoscopy _____

*Sigmoidoscopy_____

Mammogram: Date:_____

IF THE ABOVE TESTS WERE NOT PERFORMED BY THE REFERRING PHYSICIAN, PLEASE PROVIDE A COPY FOR OUR RECORDS.

Recent tests: x-rays, CT scans, MRI_____

PMH: Check if you have been diagnosed with:

❑ Abnormal liver tests	❑ Diverticulosis	❑ Jaundice (yellow eyes or skin)
❑ Anemia/low blood counts	❑ Emphysema/COPD	❑ Kidney Disease
❑ Ascites (abdominal fluid)	❑ Endocarditis	❑ Lung Disease
❑ Bleeding tendency	❑ Endometriosis	❑ Mitral Valve Prolapse
❑ Blood clots lungs or legs	❑ Epilepsy/ Seizures	❑ Pancreatitis
❑ Blood transfusions	❑ Fibromyalgia	❑ Sexually transmitted disease
❑ Bowel obstruction	❑ Heart Disease	❑ Skin disorder
❑ _____ Cancer	❑ Heart Murmur	❑ Stroke/TIA
❑ Celiac disease	❑ Heart Valve Replacement	❑ Suicide attempts
❑ Cirrhosis	❑ Hemorrhoids	❑ Tuberculosis
❑ Colon Cancer	❑ Hepatitis A, B, C	❑ Ulcerative Colitis
❑ Colon Polyps	❑ High blood pressure	❑ Ulcers
❑ Crohn's Disease	❑ HIV	❑ Other_____
❑ Diabetes	❑ Irritable Bowel Syndrome	❑ Other_____

The Colorectal Institute

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Patient Name:_____ **Date:** _____

List previous surgeries or hospitalizations:

Year	Procedure/Reason	Facility

Mark if you take:

❑Advil ❑ Aspirin ❑Excedrin ❑Aggrenox ❑BC powder ❑Ticlid ❑Ibuprofen ❑Aleve
❑Motrin ❑Coumadin ❑Plavix

List all medications you are taking. (Include dosage and how you take them)
Include over-the-counter medications and health food store products.

_____
_____
_____
_____
_____

Social History:

❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑Separated ❑ Life partner

❑ **I never smoked** ❑ **I quit smoking**_____❑months ❑years ago ❑ I usually smoke ❑cigarettes ❑cigars.

❑ **I smoke** _____ ❑cigarettes ❑packs per ❑day ❑week ❑month for _____ ❑months ❑years).

❑ **I never drink alcohol** ❑ **I quit drinking alcohol** _____❑months ❑years ago.

❑ **I have _____ drinks per** ❑day/❑week/❑month/❑year for the past _____ ❑months/❑years.

❑ I usually drink ❑liquor/❑wine/❑beer ❑ I used to drink ❑liquor/❑wine/❑beer.

Recreational drug use: Present ❑ Yes ❑No Past ◯Yes ◯No Name/Last used:_____

Family History: Please list below if any **blood relatives have had**:

Diabetes	Colon Cancer	Endometrial Cancer	Crohn's Disease
Heart Disease	Colon Polyps	Ovarian Cancer	Ulcerative colitis
High Blood Pressure	Celiac disease	Pancreatic Cancer	Stroke
		Kidney/Bladder Cancer	Any other significant disease/illness

Relative	**Disease**	**Relative**	**Disease**
Mother:		Aunts:	
Father:		Uncles:	
Brothers:		Grandparents:	
Sisters:		Other:	

The Colorectal Institute

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Patient Name:_____ **Date:**_____

If part-time resident: name, address and phone number of your out-of-state physician:

Physician: _____ Phone #: _____

Address: _____

In case of an emergency, whom should we contact:_____

Emergency Contact Phone Number(s): _____
(AN EMERGENCY CONTACT IS REQUIRED FOR ALL PATIENTS)

POWER OF ATTORNEY (POA): IF THE PATIENT HAS A COURT DESIGNATED POA REPRESENTATIVE, PLEASE ATTACH A COPY OF THE LEGAL DOCUMENTATION.

GUARDIAN/PARENT INFORMATION FOR TREATMENT OF A MINOR

If patient is a minor, please complete the following section

Mother's Name _____ Employer _____

Address _____

Contact Number(s) _____ SS# _____

Father's Name _____ Employer _____

Address _____

Contact Number(s) _____ SS# _____

Uninsured: If you are paying for services yourself, we will expect payment on the day of your visit.

ALL self pay fees will be collected at the time services are rendered.

Insurance Participants: If you do not have your insurance cards, payment is expected in full at the time services are rendered, unless other arrangements are made in advance. We WILL NOT attempt to locate insurance information for you.

ALL co-payments and deductibles are collected at the time services are rendered.

Medicare: We participate in Medicare Part B and will bill all services for you. We will be happy to bill your secondary plan for you as well.

You are responsible for your annual Part B deductible and 20% co-insurance.

Medicaid: We participate with Medicaid and Prestige Medicaid HMO. If a referral is required for your visit to our office it is your responsibility to obtain the referral and/or authorization.

You will be responsible for your co-pay, co-insurance or Share of Cost at your visit.

Referral/Authorization: Your insurance company may require a referral and/or authorization for your visit to our office. Failing to obtain the proper authorizations may cause a reduced payment or denial of payment from the insurance company.

Obtaining the referral or authorization to be seen at our office is your responsibility.

Appointment Cancellations: As a courtesy to our other patients, we request cancellations be made with at least 24 hours advance notice.

We reserve the right to apply a $75.00 charge for missed visits not cancelled with 24 hour notice.

I understand the above and certify that all the information is accurate to the best of my knowledge.

SIGNATURE _____ DATE _____

Patient, POA, Guardian (if patient is a minor)

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Colorectal Cancer Awareness

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name:_____ **Date:**_____

With my consent, The Colorectal Institute may use and disclose Protected Health Information (PHI) to carry out Treatment, Payment and Healthcare Operations (TPO). Please refer to The Colorectal Institute Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent.

The Colorectal Institute reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to:

The Colorectal Institute
13770 Plantation Rd., Suite 2
Fort Myers, Florida 33912

With my consent, The Colorectal Institute may disclose PHI to others who may assist in my medical care, such as a spouse. The Practice may call my home or other designated location and leave a message on a voice mail or in person in reference to any items that assists the Practice in carrying out TPO. This would include appointment reminders, insurance items and any calls pertaining to my medical care.

I have the right to request that The Colorectal Institute restricts how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to The Colorectal Institute's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the Practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, The Colorectal Institute may decline to provide treatment to me/my child.

I, give permission to the employees of the Colorectal Institute to release my medical information to the following family member, friend or designated patient representative.

Name:	Relationship:
Name:	Relationship:
Name:	Relationship:
Name:	Relationship:

I understand that I may revoke the above permission at any time in writing.

_____ _____
Patient or Authorized Representative Signature Date

OR

I, _____ REQUEST THAT ALL MEDICAL INFORMATION BE DISCUSSED WITH *ONLY ME*, AND NO OTHER FAMILY MEMBER.

_____ _____
Patient or Authorized Representative Signature Date

Rev 9/17

Assignment of Benefits/Right to Payment, Patient Responsibility and Release of Information Form

Colorectal Cancer Awareness

The Colorectal Institute
GenesisCare USA, Inc
PO BOX 86215 ORLANDO, FL 32886-2152

I, the undersigned, irrevocably assign to the provider/entity referenced above ("Provider"), all of my rights and benefits and any other interests that I have in any medical insurance plan, health benefit plan, indemnity plan, trust, fund or other source of payment for healthcare services (each a "Plan") in connection with medical services provided by Provider, its employees and agents. I understand that this document is a direct assignment of my rights and benefits under my Plan.

I instruct my insurance company to pay Provider directly for the professional or medical expense benefits payable to me. If my current policy prohibits direct payment to Provider, I instruct my insurance company to make out the check to me and mail it directly to the address of lockbox referenced above for the professional or medical expense benefits payable to me under my Plan as payment towards the total charges for the services rendered. In addition, I agree and understand that any funds I receive by my insurance company due for services rendered by Provider will be immediately signed over and sent directly to Provider.

Patient Responsibility

I acknowledge and agree that I am responsible for all charges for services provided to me which are not covered by my Plan or for which I am responsible for payment under my Plan. To the extent no coverage exists under my Plan, I acknowledge that I am responsible for all charges for services provided and agree to pay all charges not covered by my Plan.

Release of Information

I authorize Provider and/or its agents to release any medical or other information about me in its possession to my Plan, the Social Security Administration, any state administrative agency, or their intermediaries or fiscal agents required or requested in connection with any claim for services rendered to me by Provider.

A photocopy of this Assignment shall be considered as effective and valid as the original.

_____ Date:_____
Signature of Patient/Person Legally Responsible

_____
Print Name of Patient/Person Legally Responsible

_____
Relationship to Patient
(If signed by Person Legally Responsible)

The Colorectal Institute

GenesisCare USA, Inc

Colorectal Cancer Awareness

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge: A copy of the Notice of Privacy Practices was given to me.

If I came in for healthcare services in an emergency treatment situation, I was given the Notice as soon as reasonably practicable after the emergency treatment situation.

_____ _____

Signature of Patient or Representative Date

_____

Print Name

****

FOR OFFICE USE ONLY

If an acknowledgment is not obtained, please complete the information below:

Patient's name: _____

Date of attempt to obtain acknowledgment: _____

Reason acknowledgment was not obtained:

- ❑ Patient/family member received notice but refused to sign acknowledgment
- ❑ Emergency treatment situation
- ❑ Patient was incapacitated and no family member was present
- ❑ Unable to communicate due to language barriers
- ❑ Other (please describe below)

_____

_____

_____ _____

Signature of Employee Date

Notice of Privacy Practices
The Colorectal Institute
GenesisCare USA, Inc

Colorectal Cancer Awareness

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Each time you visit our physicians or receive treatment from us, a record of your visit is made. This record may contain your symptoms, examination and test results, diagnoses, treatment, a plan for future care or treatment, and billing-related information. This notice applies to all of the records of your care generated by your physician.

Our Responsibilities
We are required by law to maintain the privacy of your protected health information, to provide you with notice of our legal duties and privacy practices with respect to that protected health information, and to notify any affected individuals following a breach of any unsecured protected health information. We will abide by the terms of the notice currently in effect.

Uses and Disclosures - How we may use and disclose protected health information about you

For Treatment: We may use protected health information about you to provide you with treatment or services. We may disclose protected health information about you to doctors, nurses, or other personnel who are involved in taking care of you. For example, we may need to communicate with your primary care doctor to plan your treatment and follow-up care.

For Payment: We may use and disclose protected health information about your treatment and services to bill and collect payment from you, your insurance company, or a third-party payer. For example, we may need to give your insurance company information about your diagnosis so that it will pay us or reimburse you for the treatment.

For Healthcare Operations: We may use or disclose, as needed, your protected health information in order to run our practice. For example, members of the medical staff and/or quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. The results will then be used to continually improve the quality of care for all patients we serve.

We may also use and disclose protected health information:
- To business associates we have contracted with to perform an agreed-upon service
- To remind you that you have an appointment for medical care
- To assess your satisfaction with our services
- To inform you about possible treatment alternatives
- To inform you about health-related benefits or services
- To conduct case management or care coordination activities
- To contact you as part of our fundraising efforts, if any, though you will have the right to opt out of such communications
- To inform funeral directors consistent with applicable law
- For population-based activities relating to improving health or reducing healthcare costs
- For conducting training programs or reviewing competence of healthcare professionals

Individuals Involved in Your Care or Payment for Your Care: We may release protected health information about you to a friend or family member who is involved in your medical care or who helps pay for your care.

Research: We may disclose information to researchers when an institutional review board has approved the disclosure based on adequate safeguards to ensure the privacy of your health information and as otherwise allowed by law.

Future Communications: We may communicate with you via newsletters, mailings, or other means regarding treatment options, health-related information, disease management programs, wellness programs, or other community-based initiatives or activities in which our facility is participating.

As Required by Law, we may also disclose health information to the following types of entities, including but not limited to:
- The U.S. Food and Drug Administration
- Public health or legal authorities charged with preventing or controlling disease, injury, disability, or other threat to health or safety
- Correctional institutions (if you are in custody of a correctional institution or a law enforcement officer)
- Workers' compensation agents
- Organ and tissue donation organizations
- Military command authorities
- Health oversight agencies
- Funeral directors, coroners, and medical examiners
- National security and intelligence agencies
- Protective services for the president and others

Law Enforcement / Legal Proceedings: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena or court order.

Colorectal Cancer Awareness

Other Uses of Your Protected Health Information That Require Your Authorization
Uses and disclosures of your protected health information that involve the release of psychotherapy notes (if any), marketing, sale of your protected health information, or other uses and disclosures not described in this notice or required by law will be made only with your separate written permission. If you give us permission to use or disclose protected health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose protected health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission and that we are required to retain our records of the care that we provided to you.

Your Health Information Rights
Although your health record is the physical property of the healthcare practitioner or facility that compiled it, you have the right to:

- Inspect and copy protected health information. You may request access to your records by contacting us. You may also ask that we send your health information directly to another person based on your signed written instructions. We may deny your request to inspect and copy in certain, very limited circumstances. If you are denied access to protected health information, you may request that the denial be reviewed in some situations. Another licensed healthcare professional chosen by us will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review. We reserve the right to charge you a reasonable fee to cover the cost of providing you with a copy of your records.
- Request an amendment. If you feel that protected health information we have about you is incorrect or incomplete, you may ask us to amend the information by making a request in writing that explains the reason for the requested amendment. You have the right to request an amendment for as long as the information is kept for or by us. We may deny your request for an amendment; if this occurs, you will be notified of the reason for the denial.
- Request an accounting of disclosures. This is a list of certain disclosures we make of your protected health information for purposes other than treatment, payment, healthcare operations, or certain other permitted purposes.
- Request restrictions or limitations on the protected health information we use or disclose about you for treatment, payment, or healthcare operations. You also have the right to request a limit on the protected health information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. We are not required to agree to your request, except as described below. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. If you ask us not to disclose your health information to your health plan, we will agree as long as (i) the disclosure would be for the purpose of payment or health care operations and is not otherwise required by law and (ii) the information only relates to items or services that someone other than your health plan has paid for in full.
- Request confidential communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you may ask that we contact you at work or by U.S. mail. We will grant requests for confidential communications at alternative locations and/or via alternative means only if the request is submitted in writing and the written request includes a mailing address where you will receive bills for services rendered by the facility and related correspondence regarding payment for services. Please realize that we reserve the right to contact you by other means and at other locations if you fail to respond to any communication from us that requires a response.
- A paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our Web site at www.21stcenturyoncology.com.

Changes to This Notice
We reserve the right to change this notice; the revised notice will be effective for information we already have about you as well as any information we receive in the future. The current notice will be posted in the facility and will include the new effective date. Copies of any revised notices will be available on our website and will be provided to you upon your next visit to our facility after the effective date.

Complaints
If you believe your privacy rights have been violated, you may file a complaint with us by contacting our Privacy Officer toll-free at 1-866-679-8944, or by contacting the Secretary of the U.S. Department of Health and Human Services.

You will not be penalized for filing a complaint.

For further information, contact:
Privacy Officer
2270 Colonial Boulevard
Fort Myers, FL 33907
1-866-679-8944

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Colorectal Cancer Awareness

The Colorectal Institute
Telephone: 239-275-0728 Fax: 239-275-6947

Physician Financial Interest Disclosure Form

Dear Patient,

A financial interest in the following surgical facility enables your physician to have a voice in its administration and medical policy. This involvement helps ensure the finest quality patient care.

Facility Name & Address:

The Sanctuary
8960 Colonial Center Dr.
Ft. Myers, Florida 33905

You have the right to obtain the items or services for which you have been referred at this location from another provider of your choice.

The name and address of two alternative sources of such items or services are:

Gulf Coast Medical Center
13681 Doctor's Way
Ft. Myers, Florida 33912

Cape Coral Surgery Center
2721 Del Prado Blvd. S., Ste 100
Cape Coral, FL 33904

The Colorectal Institute
Colorectal Surgery
Professional Care, Personal Touch!

Lee/Collier Counties, Florida Market

Patient Protection and Affordable Care Act of 2010
Patient Disclosure for Diagnostic MRI, PET or CT Services

Dear Patient,

If your physician determines that a referral for diagnostic MRI, PET or CT services is appropriate as a part or your medical evaluation and treatment; we may have these services available at one of our locations. We will provide you information about those options.

You, however, have the freedom to choose the supplier for this service. To the best of our knowledge, the following providers furnish these services in the area:

Name: Radiology Regional Centers
Address: 6100 Winkler Rd, Ft. Myers, FL 33919

Name: Advanced Radiology Imaging Associates, LLC
Address: 13731 Metropolis Ave, Ft. Myers, FL 33912

Name: Florida Radiology Consultants
Address: 6311 Southpointe Blvd, Ft. Myers, FL 33919

Name: Naples Diagnostic Imaging Center
Address: 311 North Tamiami Trail, Ste 104, Naples, FL 34102

Name: Radiology Regional Centers
Address: 700 Goodlette Rd, Naples, FL 34102