

Gastroenterology

Syed Bin-Sagheer, M.D

Advance Gastroenterology

Name: _____ DOB: _____

Phone: _____ Address: _____

Sex: Male/ Female Drug Allergies: _____

SS #: _____

Primary Care Doctor: _____ Insurance? _____

Current Medication with dosages: _____ ID # _____

Chief Complaint: _____

Email for patient portal: _____

PAST MEDICAL HISTORY: (Please check mark all that apply)

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Congestive Heart | <input type="checkbox"/> Kidney Failure | <input type="checkbox"/> Depression | <input type="checkbox"/> Crohn's Disease |
| <input type="checkbox"/> Atrial fibrillation | <input type="checkbox"/> Skin cancer | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Ulcerative Colitis |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Asthma | <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Ulcers/Gastritis |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Gallbladder |
| <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> COPD | <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Seizures | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Stroke/TIA | <input type="checkbox"/> Acid reflux |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Lung cancer | <input type="checkbox"/> Palsy | <input type="checkbox"/> Liver Cirrhosis |
| <input type="checkbox"/> Dyslipidemia | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Anemia | <input type="checkbox"/> Gallstones |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Diverticulosis | <input type="checkbox"/> Cancer/type _____ |

PAST SURGICAL HISTORY: (Please supply date of surgery and location)

Do you smoke? ___ Yes or ___ No How many packs per day? _____ Use Marijuana? _____

How many years have you smoked? _____ What year did you quit? _____

Do you Drink? ___ Yes or No How much daily? _____ How many Years? _____

Gastroenterology

FAMILY HISTORY (Please check mark all that apply)

	FATHER Alive? Yes/No	MOTHER Alive? Yes/No	SIBLINGS Alive? Yes/No	CHILDREN Alive? Yes/No
Lung Disease	___	___	___	___
Heart Disease	___	___	___	___
Hypertension	___	___	___	___
Stroke	___	___	___	___
Cancer (Type: _____)	___	___	___	___
Diabetes	___	___	___	___
Liver Disease	___	___	___	___

REVIEW OF SYSTEM (Check all that apply)

GENERAL: ___ Fatigue ___ Weakness ___ Weight Gain ___ Weight Loss

ALLERGY: ___ Sneezing ___ Rash ___ Hives ___ Lymphadenopathy

CARDIOVASCULAR: ___ Chest Pain ___ Palpitations ___ Murmur

PULMONARY: ___ Hemoptysis ___ Wheezing ___ Snoring ___ Chest pain

RESPIRATORY: ___ Shortness of breath ___ Cough ___ Sputum ___ Hoarseness

GASTROINTESTINAL: ___ Heartburn ___ Nausea ___ Vomiting ___ Constipation
 ___ Diarrhea ___ Vomiting blood ___ Difficulty swallowing ___ Abdominal pain

RENAL: ___ Frequent urination ___ Blood in urine ___ Pain w/urination

ENDOCRINE: ___ Heat intolerance ___ Cold intolerance ___ Difficulty sleeping

NEUROLOGIC: ___ Visual Disturbances ___ Blackouts ___ Numbness

RHEUMATOLOGIC: ___ Arthralgia ___ Back pain ___ Joint pain

PSYCHIATRIC: ___ Anxiety ___ Depression

MUSCULOSKELETAL: ___ Joint pain ___ Back pain

OPHTHAMOLOGICAL: ___ Blurred vision

ENT: ___ Difficulty swallowing ___ Sore throat

Dear Valued Patient,

Thank you very much for choosing Physicians of Advanced Gastroenterology and Pulmonary care, P.L. to participate in your healthcare. As a participant in your own healthcare, it is your responsibility to make sure that there is a clear and open method of communication from our office to you. It is your duty to make sure that this office always has a way to contact you to communicate test results and other important matters relating to your medical care. Along the way, we will recommend/perform diagnostic studies which we feel are important to your well-being. These diagnostic studies serve the purpose of diagnosing your ailment, defining treatment strategies and maintaining your health. As with all diagnostic studies we are at times unpleasantly surprised by the results. The results include cancer and other potentially deadly conditions, which if gone undiagnosed or if diagnosis is delayed can result in death or serious disability. Some of these studies will be at the time of an active issue, other times it will be recommendations for the future, maybe even ten years in the future. We pride ourselves in attempting to contact every single patient with reminders for follow-up issues. Sometimes we are unable to contact you, or the results are not returned to our office. Ultimately, it is your responsibility to contact us if you do not hear within 14 days regarding your test results or if you do not receive a reminder notice for a follow-up diagnostic study.

By signing this letter, you acknowledge the imperfection in our system and agree to the following: (Please initial each line)

1. _____ Call our office 2 weeks after any diagnostic study
 2. _____ Call our office again, for any issue, if we do not return your call
 3. _____ Immediately notify our office of a change of address or contact telephone number
-
4. _____ Keep a record of when your diagnostic studies are and notify our office if you cannot comply
 5. _____ Keep a record of your future follow up needs, even if it is ten years in the future.

**Many thanks and we look forward to a mutually gratifying relationship.
Advanced Gastroenterology and Pulmonary Care, P.L**

Patient printed name: _____ Witness name: _____

Patient signed name: _____ Witness signed name: _____

Date: _____ Date: _____

PATIENT HIPPA ACKNOWLEDGEMENT AND DISIGNATION DISCLOSURE FORM:

I, _____ Acknowledge of practices HIPPA privacy notice: By subscribing my name below, I acknowledge that Advanced Gastroenterology and Pulmonary Care, P.L has provided a copy of HIPPA privacy notice, and that I have read and understand my rights and ask questions regarding my rights and receive answers to my satisfaction, and agree to its terms.

Name Signature of Patient Date

Designation of certain Relatives, Close Friends and other Caregivers as my Personal Representative:

Name: _____ Phone #: _____
Name: _____ Phone #: _____
Name: _____ Phone #: _____

Request to receive Confidential Communications by Alternative Means:
As provided by Privacy Rule Section 164.522(b). I hereby request that the practice make all communications to me by the alternative means that I have listed below.

Phone #: _____ Email: _____

Written Communication Address: _____

NAME OF PATIENT SIGNATURE OF PATIENT DATE

NAME OF WITNESS SIGNATURE OF WITNESS DATE

ASSIGNMENTS OF BENEFITS

I, _____, hereby authorize _____
Name of insurer/ Patient Name of Insurance Carrier

To make medical benefit payments, otherwise payable to me for services rendered by the physician and staff, payable to and mailed directly to:

Advanced Gastroenterology & Pulmonary Care, P.L
7128 Sagheer Street, Brooksville Fl 34601

Furthermore I hereby IRREVOCABLY ASSIGN to Advanced Gastroenterology and Pulmonary Care, P.L the rights and benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statutes for any service and/or charges, provided by Advanced Gastroenterology and Pulmonary Care, P.L. Furthermore the undersigned by these present does hereby make, constitute and appoint Advanced Gastroenterology and Pulmonary Care, P.L and any of it duly authorized agents and employees as and to be the undersigned's true and lawful attorney for and in the undersigned's name place and stead to endorse any and all checks, drafts, or money orders which are made payable to the undersigned alone or the undersigned and the said Advanced Gastroenterology and Pulmonary Care, P.L at the request or with the knowledge and approval of the undersigned and/or the maker of the check, draft, or money order. Furthermore, the undersigned Advanced Gastroenterology and Pulmonary Care, P.L or any of its agents to sign any paper that will be necessary to enhance, expedite and/or allow payment to said provider. This may include insurance forms and other statements. The undersigned does hereby ratify and confirm all actions taken by the said attorney in accordance with this special power and which the said attorney shall do or cause to be done by virtue of these present.

MEDICAL RELEASE

Furthermore, a photocopy of this document shall be sufficient to authorize any person having records of medical treatment, services, or supplies pertaining to me to release true copies of same to Advanced Gastroenterology and Pulmonary Care, P.L or any insurer providing coverage to me in connection with the processing of any claim for benefits made by me or by the assignee herein. A photocopy of this document shall be binding as an original signature page.

CONSENT TO TREAT

I authorize Advanced Gastroenterology and Pulmonary Care, P.L to perform the treatments or procedures approved by my physician. I acknowledge that no guarantees, either expressed or implied, have been made to me regarding the outcome of any treatments and or procedures. The nature and purpose of the procedure, possible alternative methods of treatment and risks involved, and the possibilities of complications have been fully explained to me.

IN WHITNESS WHEREOF- the undersigned have here unto set their hands, this _____ day of _____, 20_____.

Patient name Patient Signature Date

FINANCIAL POLICY:

Our practice is due at the time of service unless arrangements have been made in advance by your carrier. We accept most major credit cards. There will be a minimum charge of \$25.00 for returned checks. Please be advised that your insurance policy is basically a contract between you and your insurance company. As a service to our patients, we will file your insurance claim if you assign the benefits to the doctor. We are participating providers with many insurance companies and other health plans. Prior arrangements have been made to accept assignment of benefits. We will bill your insurance for services provided. However, you are required to make your co-payment or pay any deductibles at the time of service. If you are insured by a plan that we do not participate with, charges for your care are due at the time of service. However, we will prepare and send a claim for you on an unassigned basis, this means your insurance company will send payment directly to you. Not

all insurance plans cover all services. In the event that your insurance plan determines a service to be "not covered", you will be responsible for the entire charge.

If you provide incorrect or false insurance information you will be responsible for any unpaid claims and or all charges for services provided. We will bill your insurance company for services that are provided to you by us in the hospital. If your insurance does not pay you will be responsible for any balances due.

NO SHOW AND CANCELED APPOINTMENTS: Please be advised there will be a \$25.00 cancellation fee for all appointments cancelled or no showed with less than 48 hour notice.

NOTICE OF FORM FEES AND RECORDS FEE: There will be a fee for all paperwork that needs to be filled out or signed by Dr. Bin-Sagheer. We will also assess a fee for any records. Personal records may be obtained for a fee of \$1.00 a page for the first 25 pages and \$0.50 a page there after.

By signing below, I acknowledge that I have read and understand the terms listed above.

Patient Name

Patient Signature

Date

ADVANCE GASTROENTEROLOGY AND PULMONARY CARE

MEDICAL RECORD RELEASE FORM

Patient Name: _____ Date of Birth: ____/____/____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____

INFORMATION REQUESTED FROM

Name: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____

Email: _____

SEND INFORMATION TO:

Name: Dr. Syed Bin- Sagheer Send by Mail Fax Secure Email

Address: 7128 Sagheer Street City: Spring Hill

State: Florida Zip: 34613 Phone: (352)345-4876

Fax: (352)345-4880 Email: _____

The Information you may release subject to this signed release form is as follows:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Complete Records | <input type="checkbox"/> Care Plan | <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> Hospital reports |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Lab reports | <input type="checkbox"/> Treatment record | <input type="checkbox"/> Medication record |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Operative reports | <input type="checkbox"/> Others (Please specify) |

I, _____ (Name), hereby grant permission for you to release confidential health information about me, by releasing a copy of my medical record, or a summary or narrative of my protected health information, to the physician/person/facility.

Printed Name

Date

Signature

Date