GASTROENTEROLOGY
INSTITUTE OF ORLANDO

WELCOME TO OUR PRACTICE

Please fill out this form from your desktop or mobile device, save it, send it to gastro@-gio.care, or print to fill it out by hand and fax it to (407) 201-3739.

Please leave no blank, if something does not apply write N/A and if unknown, wirte unknown. ***Por favor, no dejar espacios en blanco. Si algo no se aplica escriba N/A y si no sabe, escriba nose.***

PERSONAL IMFORMATION *(Información Personal)*

Name: _____ Date of Birth: ____/____/_____ Age:_____
Nombre *Fecha de Nacimiento* *Edad*

Address: _____ Apt. _____
Dirección *Apartamento*

City: _____ State: _____ Zip: _____
Ciudad *Estado* *Codigo Postal*

Home phone : ( ) _____-_____-_____ Cell phone: ( ) _____-_____-_____
Teléfono de casa *Celular*

Social Security Number: _____ Email: _____
Número de Seguro Social *Correo electrónico*

Marital Status: Married ◯ Single ◯ Divorced ◯ Widowed ◯ Separated ◯ Gender: Male ☐ Female ☐
Estado Civil *Casado(a)* *Soltero (a)* *Divociado (a)* *Viudo (a)* *Separado (a)* *Genero* *Masculino Femenino*

EMERGENCY CONTACTS *(Contactos de emergencia)*

Name: _____ Last Name: _____ Phone: ( ) _____-_____-_____
Nombre *Apellido* *Teléfono*

Primary Care Physician: *(Medico Primario)*

Name: _____ Last Name: _____ Phone: ( ) _____-_____-_____
Nombre *Apellido* *Teléfono*

Referring Physician: *(Medico referido)*

Name: _____ Last Name: _____ Phone: ( ) _____-_____-_____
Nombre *Apellido* *Teléfono*

Pharmacy Contact: *(Contacto de farmacia)*

Name: _____ Last Name: _____ Phone: ( ) _____-_____-_____
Nombre *Apellido* *Teléfono*

INSURANCE INFORMATION *(Informacion del seguro médico)*

Primary Insurance Company: _____ Phone: ( ) _____-_____-_____
Primera compañía del seguro médico: *Teléfono*

Name of Policy Holder: _____ Phone: ( ) _____-_____-_____
Nombre del asegurado *Teléfono*

Social Security: _____ Relationship to Paptient : _____
Número de seguro Social *Relacion con el pacientte*

Secondary Insurance Company: _____ Phone: ( ) _____-_____-_____
Segunda compañía del seguro médico *Teléfono*

Name of Policy Holder: _____ Date of Birth: _____/_____/_____
Nombre del asegurado *Fecha de Nacimiento*

Social Security: _____ Relationship to Paptient : _____
Número de Seguro Social *Relacion con el pacientte*

Benefit Assigment & Acknoweledgement of Finatial Responsibility

I authorize the Insurance mentioned earlier to make payment directly to the Gastroenterology Institute of Orlando for the Medical Services I receive. I understand that I am financially responsible for all non-covered services, co-pays, co-insurance, deductibles, and other charges my insurance company deems my responsibility. If my account became delinquent for a period of (30) days or more, I hereby acknowledge that I will be responsible for the entire balance, interest, court costs and/or attorney's fees that may be incurred in the collection of my depth.

I autorizo a mi compañía de seguros para hacer el pago directamente a Gastroenterology Institute of Orlando por los servicios médicos que reciba. Entiendo que soy financieramente responsable de todos los servicios no cubiertos, co-pagos, co-seguros, deductibles y otros gastos que mi compañía de seguros considera que son mi responsabilidad. En caso de que mi cuenta se convierta en delincuente por un periodo de (30) días o más, reconozco que seré responsable de el saldo completo, intereses, costos judiciales y/o honorarios de abogados que puedan incurrir en la colección de mi deuda.

Signature _____ Date: _____/_____/_____
Firma *Fecha*

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DISEASE OR SYMPTOMS

Please check “YES or ”NO” for all that apply

GASTROINTESTINAL	YES	NO	RESPIRATORY	YES	NO	SKIN	YES	NO
Diarrhea			Asthma			Rash		
Constipatioin			Pneumonia			Rosacea		
Rectal bleeding			Bronquitis			Psoriasis		
Cancer			Caugh			Skin cancer		
Change in bowel movements			Hoarseness			**EAR, NOSE, THROAT**		
Weight loss			Trachetomy			Cancer		
Polyps			**RENAL/URINARY**			Nosebleed		
Irritable bowel syndrome (IBS)			Chronic kidney disease			Deafness		
Crohns disease			Urinary tract infection			Sinusitis		
Ulverative colitis			Kidney transplant			Adenoiditis		
Trouble swallowing			Frequent urination			**BREAST**		
Nausea / Vomiting			**ENDOCRINE**			Cancer		
Heartburn			Diabetes			Lumps		
Abdominal pain			Elevated blood sugar			Mastectomy		
CARDIAC			Thyroid disorder					
Abnormal EKG			**MUSCULOSKELETAL**					
High blood pressure			Muscle ashes					
Low blood pressure			Neck pain					
Angina								
High Cholesterol								

Please list any disease or symptoms not mentioned above: _____

_____

_____

_____

Please list all your medications:

NAME	STRENGTH	DIRECTIONS

Signature _____ Date: _____/_____/_____

812 W Oak Street, Kessimmee, FL 34741 | email: gastro@gio.care | (407) 201-3686 | Fax: (407) 201-3739
1111 S. Semoran Blvd. Orlando, FL 34741 | email: cardio@gio.care | (407) 480-4445 | Fax: (407) 480-4446

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Acknowledgement of Receipt of Privacy Practices

I understand that as my healthcare, this organization originates and maintains health records describing my health, symptoms, examinations and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I have been provided with a notice of Privacy Practices that gives a complete description of information uses and disclosures as a description of my privacy rights. I understand that I can review the note before signing these acknowledgments. I know that the organization reserves the right to change its notice and practices and will provide me a copy of any revised information.

Patient Name: _____ Witness: _____

Signature _____ Date: _____/_____/_____

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Financial Policy

The Gastroenterology Institute of Orlando has a responsibility to provide quality healthcare services to patients. In maintaining a good patient relationship and continuing the delivery of quality healthcare, we hope you will take responsibility for your financial obligation to our practice. The following are general policies we have established for our patients, which allow some patients flexibility. We encourage you to discuss your account and any payment arrangement that you desire with our office personnel. Discussion of these issues early on in your treatment process will prevent most concerns or misunderstandings.

1- **INSURANCE** - As a courtesy to our patients, we file claims of all visits and procedures, either they are delivered in our office or in the hospital. When we file a claim on your behalf, it is with the understanding that benefits will be assigned to the Gastroenterology Institute of Orlando. That is, the insurance company will pay the Gastroenterology Institute of Orlando directly). You are responsible for the payment of all deductibles, co-insurance, co-pays, and non-covered services. Please remember that insurance coverage is a contract between the patient and the insurance company. The ultimate responsibility for understanding your insurance benefits and for payments to your doctor rests with you.
2- **REFERRALS** - You are required to know whether or not your insurance requires a referral/authorization and obtain that referral/authorization before you are scheduled to see our physicians. Our office will be happy to assist you in determining the status of any one of our doctors on your insurance plan; however, this is not a guarantee of coverage. You should take the time to call your insurance company to ask specifically about the doctor you wish to see and your coverage benefits. Referral typically has an expiration date and a limited number of visits, so you should be careful to monitor dates and visits. Our office will not see a patient who does not have a visit referral.
3- **PROCEDURES** - No show for procedures; your account will be charged an administrative fee of $100.00
4- **APPOINTMENTS** - New patients “No-show be charged an administrative fee of $50.00
5- **RETURNED CHECKS** - Your account will be charged $30.00 for each returned check. In addition, you will be asked to bring cash to our office to cover the returned check and the fee.
6- **PAST DUE ACCOUNTS** - Patients who have not made an effort to make payment arrangements to have not expressed an interest in meeting their financial obligation to us may be turned over to a collection agency. Patients who have allowed their accounts to be turned into an agency will be expected to satisfy their financial obligation and pay for any future services in advance before being seen by our physicians.
7- **NON-COVERED SERVICE*S*** - You have scheduled a visit with one of our physicians and physician believes to be relevant to evaluate, monitor, and protect your health. However, Medicare and certain other insurance companies will only pay for services that determine to be “reasonably necessary”; they will deny payment for that service. Sometimes insurance companies will not cover an office visit before a procedure when the patient comes to the doctor with no symptoms and requests a screening procedure. Denial of payment by your insur-ance company does not mean that you need to visit a physician assistant beforehand.

Our doctors recommend an office visit prior to the performance of any procedure in order to have the patient’s general health evaluated and make sure the patient is well informed about the recommended procedure. We are required to notify you that your insurance company may not cover the office visit and that you will be responsible for payment.

PATIENT SETTLEMENT - BENEFIT ASSIGNMENT & ACKNOWLEDGMENT OF FINANCIAL RESPONSIBILITY I authorize the insurance mentioned before to make payments directly to the Gastroenterology Institute of Orlando for the medical services I receive. I understand that I am financially responsible for costs of all non-covered services, co-pays, co-insurance, deductibles, and any other charges my insurance company deems my responsibility. If my account became delinquent for a period of (30) days o more, I hereby acknowledge that I will be responsible for the entire balance, interest, court costs, and /attorney’s fees involving the attempt to collect the debt.

Signature _____ Date: _____/_____/_____

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Authorization to Release Healthcare Information

Name: _____ Date of Birth: ____/____/_____
Nombre *Fecha*

Previous Name:_____ Social Security Number. _____
Nombre Anterior *Número de Seguro Social*

I hereby request and authorize: _____
to release healthcare information pertaining to myself to the: (*Yo autorizo a la oficina del doctor aquí mencionado, el divulgar información a acerca de mi estado de salud a:*)

The Gastroenteroly Institute of Orlando
812 W. Oak St.
Kissimmee, FL 34741
(407) 201-3686
Fax: (407) 201-3739

The Cardiovascular Institute of Orlando
1111 S. Semoran Blvd.
Orlando, FL 32807
(407) 480-4445
Fax: (407)480-4446

This authorization applies to the following: (Esta informacion unicamente a lo siguiente)

All Healthcare information relating to eh following treatment, condition with respective dates:
Toda información médica en relacion a mi condicion, tratamiento con fechas

_____

_____

All Healthcare information generated by the Gastroenterology Institute of Orlando:
Toda información generada por Gastroenterology Institute of Orlando

_____

_____

All Records:
Todos los expedientes médicos

_____

_____

Definition of sexually transmitted disease (STD) as defined by law, RCW 70.24, et.seq., includes herpes, herpes simplex, human papillomavirus, wart, genital warts, condyloma, chlamydia, nonspecific urethritis, syphilis, VDRL, chancroid, lymphogranulomavenereum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.
Definición de enfermedades de transmisión sexual (ETS) como lo define la ley, RCW 70.24, et.seq., incluye herpes, herpes simple, virus de papiloma humano, verrugas, verrugas geniles, conilomas, clamidia, uretritis inespecifica, sifilis, VDRL, chancro blando, linfogranuloma, venereuem, VIH (Virus de Inmunodeficiencia Humana), SIDA (Sindrome de inmunodeficiencia adquirida, y gonorrea.

Yes☐ No☐ I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.
Yo autorizo la entrega de los resultados de mi enfermedad de transmisión sexual, VIH/SIDA, ya sea negativa o positiva, a la persona(as) mencionadas anteriormente. Yo entiendo que la persona(s) mencionada anteriormente se le notificara que tengo que dar permiso por escrito antes de divulgar las pruebas y resultados.

Yes☐ No☐ I authorize the release of my records regarding drug, alcohol, or mental health treatment to the person(s) listed above.
Yo autorizo divulgar todos los registros con respecto al consumo de drogas, alcohol y tratamiento de salud mental a las persona(s) mencionadas anteriormente.

Signature _____ Date: _____/_____/_____