GASTROENTEROLOGY
INSTITUTE OF ORLANDO

WELCOME TO OUR PRACTICE

LOCATIONS:
812 W Oak Street, Kissimmee, FL 34741
1111 S. Semoran Blvd. Ste. B. Orlando, FL
Email: gastro@gio.care | Office: (407) 201-3686 | Fax: (407) 201-3739

PERSONAL INFORMATION *(Personal Information)*

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

Address: _____ Apt. _____
Dirección *Apartamento*

City: _____State: _____ Zip: _____ Home phone : (___)-_____-_____
Ciudad *Estado* *Código Postal* *Teléfono de casa*

Cell phone: (____)-_____-_____ Social Security (Last four digits) -_____ Email: _____
Celular *Ultimos cuatro digitos del social security* *Correo electrónico*

Marital Status:__ Married __Single __Divorced__ Widowed__ Separated Gender:___ Male ___ Female
Estado Civil *Casado* *Soltero* *Divorciado* *Viudo* *Separado* *Género* *Masculino* *Femenino*

EMERGENCY CONTACTS *(Contactos de emergencia)*

FAMILY OR FRIEND CONTACT: (*Contacto del miembro de familia o amigo(a)*
Name: _____Last Name: _____ Phone: (__) _____-_____-_____
Nombre *Apellido* *Teléfono*

PRIMARY DOCTOR CONTACT: (*Contacto del médico primario*)
Name: _____Last Name: _____ Phone: ( ) _____-_____-_____
Nombre *Apellido* *Teléfono*

PHARMACY CONTACT: (*Contacto De Farmacia*)
Name: _____ Phone: ( ) _____-_____-_____
Nombre *Teléfono*

INSURANCE INFORMATION (Información del seguro médico)

Insurance Company: _____ Member ID # _____
Primera compañía del seguro médico *Numero de Miembro*

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

Secondary Insurance Company: _____ Member ID # _____
Primera compañía del seguro médico *Numero de Miembro*

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

BENEFIT ASSIGNMENT & ACKNOWLEDGEMENT OF FINANCIAL 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 becomes 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.

Yo 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, deducibles 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 del 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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Acknowledgement of Receipt of Privacy Practices

I understand that as my healthcare provider, 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 with a copy of any revised information.

Patient Name: _____ Witness: _____
Signature _____ Date: _____/_____/_____

RESEARCH NOTICE

This is a notice for the patients of the Gastroenterology Institute of Orlando. This practice is affiliated with Revival Clinical Research, and you may be contacted for one of these studies. These studies provide compensation for time and travel. Your participation is voluntary.

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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 treatmentprocess will prevent most concerns or misunderstandings.

1- INSURANCE - As a courtesy to our patients, we file claims about all visits and procedures, whether 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 a fee of $50.

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 and 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 SERVICES - You have scheduled a visit with one of our physicians and physicians believe to be relevant to evaluate, monitor, and protect your health. However, Medicare and certain other insurance companies will only pay for services that are determined 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 insurance 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 the costs of all non-covered services, co-pays, co-insurance, deductibles, and any other charges my insurance company deems my responsibility. If my account becomes 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 /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
The Gastroenterology Institute of Orlando
812 W. Oak St. Kissimmee, FL 34741
(407) 201-3686 Fax: (407) 201-3739

This authorization applies to the following: *(Esta información únicamente a lo siguiente*)
All Healthcare information relating to eh following treatment, condition with respective dates: Toda información médica en relación a mi condición, 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
_____
_____

Signature _____ Date: _____/_____/_____

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HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Date ____/____/ 20____

THE PATIENT: This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

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

THE PATIENT: This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

AUTHORIZATION: I authorize _____ (“authorize party”) to use or disclose the following :(check one)

_____ - All of my medical related information
_____ - My medical information ONLY related to : _____
_____ - My Medical related information from ____/____/_____ to ____/____/_____
_____ - Other

Hereinafter known as the “Medical Records.”

ACKNOWLEDGEMENT OF RIGHTS

I understand that I have the right to revoke the authorization, in writing and at any time, except where uses or disclosures have already been made based upon my original permission. I might not be able to revoke the authorization if its purpose was to obtain insurance

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that medical records and information used or disclosed with my permission may be re-disclosed by a recipient and no longer protected by the HIpaa Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create Medical Records for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is valid as the original.

Signature _____ Date: _____/_____/_____

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!ATTENTION!

OFFICE APPOINTMENTS:

All NO SHOWS or Cancellations with less than 24 hours will be charged a $50 cancellation fee.

No exceptions

PROCEDURES:

No shows or cancellations less than 48 hours will be charged $100.

Fee will be charged before rescheduling.

By signing this form, I agree to the given terms

Signature _____ Date: _____/_____/_____