KEY WEST SURGICAL GROUP

DEMOGRAPHIC / INSURANCE FORM

Name: _____ Date of Birth: _____
First Middle Last

Address: _____
Street City State Zip

Cell Phone #: (____) ____-____ Home Phone #: (____) ____-____
Area code Area code

Social Security Number: _____

Gender: ☐Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Other

Race: ☐ White ☐ American Indian/Alaska Native ☐ Asian/Pacific Islander ☐ Black/African American
☐ Middle Eastern American ☐ Multiple race ☐ Other

Ethnicity: ☐Hispanic/Latino ☐ Not Hispanic/Latino

Emergency Contact:

Name: _____ Phone number: (____) ____-____ Relationship: _____
First Last Area code

Employment:

Employment Status: ☐Employed ☐Disabled ☐Retired ☐Part-time ☐Not-employed ☐Student

Employer: _____ Employer Phone #: _____

Insurance Information:

Primary insurance carrier: _____ Policy number: _____

Secondary insurance carrier: _____ Policy number: _____

Policy holder name (if not the patient): Relationship to patient: Policy holder DOB:

_____ _____ _____

Primary Care / Referring Physician:

Primary Care Physician: _____ Physician phone number: (____) ____-____
Area code

Referring Physician: _____ Referring physician number: (____) ____-____
Area code

Preferred Pharmacy:

Preferred Pharmacy: _____ Phone number: (____) ____-____
Area code

KEY WEST SURGICAL GROUP

CLINICAL HISTORY FORM

Name: _____ Date of Birth: _____
First Middle Last

What is the reason for your visit?

_____
_____
_____

What symptoms/problems are you experiencing?

_____
_____
_____

New problem or have you been treated before for this problem:

☐New problem ☐I have been treated for this problem before

Are you allergic to any of the following?

☐Penicillin ☐Aspirin ☐Codeine ☐Local Anesthetics ☐Acrylic ☐Metal ☐Latex ☐Sulfa drugs	
☐Other:	If yes, please describe reaction:

List all medication that you are currently taking

Medication name	Dose and Frequency	Reason for taking:
A)		
B)		
C)		
D)		
E)		
F)		
G)		

Have you ever had a reaction to anesthetics or anesthesia during a procedure?

☐Never had a reaction ☐I **HAVE** had a reaction to *anesthesia* during a procedure ☐ I **HAVE** had a reaction to *anesthetics*

Do you currently smoke?

☐No ☐Yes How much? _____ ☐Quit When? _____

Do you consume alcohol?

☐No ☐Yes How much? _____ ☐Quit When? _____

Do you use street or recreational drugs?

☐Never used ☐Marijuana ☐Amphetamines ☐Barbiturates ☐Opioids ☐Cocaine ☐Other _____
☐Quit When? _____

Female patients only:

Are you currently pregnant? ☐No ☐Yes Date of last menstrual cycle: _____
Are you currently breastfeeding? ☐No ☐Yes Birth control method: _____
Date of last pap or GYN exam: _____ Date of last breast exam: _____

Name: _____

Please mark any medical problems / diagnoses that apply

☐Hypertension / High B.P	☐COPD	☐Non-organic sleep apnea	☐Pneumonia
☐Chest pain	☐Esophageal reflux	☐High cholesterol	☐Tuberculosis
☐Edema (fluid retention)	☐Cholecystitis (Gallbladder)	☐Coronary Artery Disease	☐Gastric Ulcer
☐DVT of lower extremity	☐Hemorrhoids	☐Obesity	☐Chronic liver disease
☐Seizure	☐Irregular menses	☐Stroke symptoms	☐Polyps of colon
☐Depression	☐Kidney disease	☐Headache	☐Kidney stones
☐Diabetes Mellitus	☐Gout	☐Anxiety	☐Arthritis
☐Asthma	☐Thyroid disorder	☐Cataract	☐Psoriasis
☐Anemia	☐Migraine Headache	☐Polycystic Ovarian Syndrome	☐Systemic Lupus
☐Cancer	☐Macular Degeneration	☐Urinary Tract Infection	☐Emphysema
☐Heart Disease	☐Abdominal pain	☐Hematologic Disorder	☐Glaucoma
☐Congestive Heart Failure	☐Gall stones	☐Erythematosus (SLE)	☐Colon Cancer
☐Transient Ischemic Attack	☐Diverticulitis of colon	☐Osteoporosis	☐None

☐Other _____

Please mark any past surgical procedures:

☐No Surgical History	☐Knee surgery	☐Back surgery	☐Cesarean section
☐Colon surgery	☐Tonsillectomy	☐Ankle surgery	☐Shoulder surgery
☐Hernia repair	☐Appendectomy	☐Breast lumpectomy	☐Hemorrhoidectomy
☐Prostate surgery	☐Hysterectomy	☐Cholecystectomy	☐Vasectomy

☐Other: _____

Do you have a family history of health conditions?

☐No family history of health conditions ☐Family history of health conditions ☐Family history unknown

Family Member	Health Condition	Reason for Death:	Age at Death

Key West Surgical Group: **Colonoscopy Questionnaire**

Patient Information:

Patient Name:	Date of Birth:

What symptoms or problems are you experiencing (if applicable)? Or, is this a screening procedure?

Are you registering for a colonoscopy?
☐Yes ☐No ☐Other: _____

Have you ever had a colonoscopy?
☐Yes ☐No ☐Unsure

When and where was your last colonoscopy performed?
Facility: _____ Date performed: _____

Did you have a colon polyp removed and if so what were the results?
Biopsy? (Polyp removed) ☐ No ☐ Yes ☐ Unsure

If a biopsy was done, write the results if known:
_____

Have you ever been diagnosed with colon cancer or any other cancer?
☐ No Cancer Diagnosis ☐ Colon Cancer ☐ Other Cancer: _____

Do you have a first degree relative (Parent, sibling, child) with a history of colon cancer?
☐ No History of Colon CA ☐Parent with Colon CA ☐Sibling with Colon CA ☐Child with Colon CA

If there is anyone else in your family not listed in the previous question with history of colon cancer or colon polyps please list below. (ie: maternal aunt, maternal aunt, maternal grandmother)

_____
_____
_____

Do you weight more than 350 lbs? ☐ Yes ☐ No

Do you have insulin dependent diabetes, electrolyte abnormalities, significant disease, or require dialysis?
☐ Not applicable ☐ Insulin dependent ☐ Electrolyte abnormalities ☐ Kidney disease ☐ Require dialysis

Are you currently experiencing rectal bleeding, diarrhea, abdominal pain, low blood counts (anemia) or unintentional weight loss? Mark all that apply and briefly explain in the line below:
☐ Not applicable ☐ Rectal bleeding ☐ Low blood counts (anemia) ☐ Abdominal pain ☐ Diarrhea
☐ Unintentional weight loss

_____

Have you ever had an episode of diverticulitis? ☐ Yes ☐ No ☐ Unsure

Do you have a history of either Crohn's disease or Ulcerative Colitis?

☐ Neither ☐ Crohn's disease ☐ Ulcerative Colitis ☐ Unsure

Do you have a pacemaker, defibrillator, or heart stents?

☐ Neither ☐ Pacemaker ☐ Defibrillator ☐ Heart stents

Do you have any active/uncontrolled heart or lung symptoms or medical conditions? (History of heart bypass, heart valve surgery, emphysema, COPD, CAD) if so use the line below to briefly explain:

☐ Yes ☐ No

_____

Are you currently being treated for an infectious disease? If other us the line below to briefly explain

☐ Not applicable ☐ HIV ☐ Hepatitis B ☐ Hepatitis C ☐ Tuberculosis ☐ MRSA

☐ Other:_____

_____

Are you currently taking any prescription blood thinning medications besides Aspirin?

☐ Not applicable ☐ Coumadin ☐ Warfarin ☐ Lovenox ☐ Xarelto

☐ Arixtra ☐ Plavix ☐ Effient ☐ Eliquis ☐ Other:_____

Are you on supplemental oxygen? ☐ Yes ☐ No

Are you able to walk up a flight of stairs or light/moderate physical activity without chest pain or shortness of breath?

☐ Yes ☐ No

Have you ever had difficulties with sedation or anesthesia? If yes, please use the line below to briefly explain:

☐ Not to my knowledge ☐ Yes ☐ Unsure

_____

Please list the name of your primary care physician. If you do not have a primary care physician, please list the name of the physician who recommended this procedure:

_____

_____

_____

If you have any additional information you believe may be important for the doctor to be aware of, please describe in the space below

_____

_____

_____

The information provided is correct and true to the best of my knowledge. (Please sign)

_____ _____

Signature Date

Key West Surgical Group, Inc
3136 Northside Drive, Key West, FL 33040

Phone: 305-294-1041
info@keywestsurgicalgroup.com
www.keywestsurgicalgroup.com

PATIENT CONSENT

Assignment of Insurance Benefits and Payment Guarantee: In consideration of services provided, I hereby assign and transfer to *Key West Surgical Group (KWSG)*, *Inc* any and all rights, which I have against insurance companies or third party payers, for payment of charges for services provided by *KWSG* to me or to one of my dependents. I authorize said payments to be applied to any unpaid balance for which I am responsible. I understand that I am responsible for and will pay the portion of my bill not covered by insurance companies or third party payers. I agree to pay the account in full upon receipt of my billing statement unless payment arrangements are made with *KWSG*. If I fail to make payment when due and the account becomes delinquent or is turned over to a collection agency, I agree to pay all collection agency fees, court costs, and attorney's fees. I also agree that any patient of guarantor overpayments may be applied directly to any delinquent account for which I or my guarantor is legally responsible. I consent for *KWSG* to work with my insurance company(s) on my behalf on authorization, appeal on my behalf for any denial of reimbursement, coverage or payment for services and care provided to me. **It is our policy that any insurance co-pays and deductibles or any balance of a bill owed by those without insurance is due at the time of service.**

Consent For E-Prescribing Electronic Prescribing: I understand that *Key West Surgical Group, Inc* may use an electronic prescription system that allows prescriptions and related information to be electronically transmitted between physicians and pharmacies. I understand that the providers using Electronic Prescribing have access to information about medications I am already taking, including those medications prescribed by other providers. I give consent to the providers of KWSG to see this protected health information (PHI).

Notice of Privacy Practices (HIPAA): Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I acknowledge I have received a copy of *KWSG* Notice of Privacy Practice. I hereby consent to the use and disclosure of my protected health information (PHI) including information generated through the utilization of virtual health or telemedicine services, as described in the Notice of Privacy Practices. I understand that this includes all of the PHI described below.

Consent to Release Health Information: I understand that KWSG uses an electronic health record system (EHR) to maintain my medical record. I understand that the electronic medical record contains information about my health from past, current, and future health care providers. I agree that my PHI may tbe released through *KWSG's* EHR or by other means (fax, telephone, email, & hand delivery) to:

- TREATING PHYSICIANS on staff at *KWSG* and their staff, agents of another healthcare facility if direct transfer to another facility is required, and to my primary care physician or any referred consultants for follow up care.
- INSURANCE COMPANY or other third-party payer and their agents as well as any review organization or government agency for the purpose of determining eligibility and available benefits, obtaining payment for services provided, and insuring government compliance.

These people may use my PHI to provide treatment, to seek reimbursement for services, and maintain operations in managing my care, patient safety protocols, and other activities necessary to operate a physician's clinic. I understand that these people may have access to all information contained in my medical record. I understand that my medical record may contain but is not limited to information concerning reproductive and sexual health information, communicable diseases, genetic information, behavioral health & substance abuse. I understand that I may revoke this consent at any time in writing, except if my PHI has already been released. I understand that I may also request in writing a list of all healthcare organizations that have received my PHI. This consent will expire one year after my death.

PLEASE SIGN ON THE BACK

General Consent for Treatment and Services: I have been informed of the treatment and procedures considered necessary for me and that the treatment procedures **will be directed by a physician,** in accordance with Florida state laws, the scope of the practice, and licensure of medical staff. I acknowledge and understand that during the course of my treatment, it may become necessary for my physician, nurse, or other health care provider to examine sensitive areas, including, but not limited to the vagina, penis, testicles, and/or rectum. I further acknowledge and understand that these activities are a not a Pelvic examination and that if during the course of my treatment, I am to have a Pelvic examination, I will receive a separate consent specifically for consent to a Pelvic examination unless said examination is Court Ordered or is immediately necessary to avert the risk of imminent, substantial and irreversible physical impairment.

Consent for Telemedicine Services: I hereby consent to telemedicine services as part of my treatment, when available and advisable by the physician. I understand that telemedicine includes providing health care, diagnoses, consultation, treatment, and transfers medical data and information using interactive audio and video services, where the patient and provider are not in the same physical location. The interactive systems will utilize systems and software with security protocols to protect the confidentiality of patient identification and PHI. I understand the potential risk of telemedicine includes, but is not limited to poor data transfer and a lack of access to my complete medical record by the provider. I understand that all information transmitted through the use of telemedicine will be part of my medical record and subject to the same restrictions and regulations outlined above with respect to the confidentiality and privacy of my PHI. I understand that I may revoke my consent in writing at any time to the consent for telemedicine.

Communications: I consent to the physicians and staff of *KWSG* contacting me via the methods I have provided to KWSG. I understand these communications may be, but are not limited to phone calls and voicemails to cellular and landline phones; use of automated telephone dialing systems, use of artificial or prerecorded voice messages, text messages, or email messages. I understand the communications may be about any matter, including, but not limited to scheduling, billing, and collection matters. I understand these communications are not encrypted or secure and assume the risks of transmitting health information via unsecure means. I understand I am responsible for any standard data and text message charges I might incur utilizing these communications. I understand that I am able to amend the forms of communication on file at any time by contacting *KWSG*. This consent applies to any updated contact information I provide.

Compliance: I understand that there is a 24-hour cancellation policy and if I fail to appear for a scheduled appointment without notifying *KWSG* within 24 hours, I will be responsible for payment of a cancellation fee, and may forfeit any monies made in prepayment to schedule the appointment. I also understand that I may be dismissed from KWSG in the case of noncompliance. This includes non-adherence to the instructions regarding prescribed medications, and treatment plans, repeatedly missing appointments, and the failure to pay the fees for services rendered and determined as obligatory by my insurance and the guidelines of this practice.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE:	NAME OF PATIENT:	DATE:
NAME OF PERSON SIGNING IF OTHER THAN PATIENT	RELATIONSHIP TO PATIENT:	

KEY WEST SURGICAL GROUP

MEDICAL RECORDS REQUEST

In the event that we need to request medical records from another medical institution, we ask you to sign this document to provide consent. **Please note that only your signature is requested**

Patient Information:

Name: _____ Date of Birth: _____
First Middle Last

Below this line for medical staff only

Requesting records from: _____ Facility Address: _____

Facility phone number: ( ) - _____ Facility fax number: ( ) - _____
Area code Area code

Please remit via: ☐Fax ☐Mail ☐Email

Please include records pertaining to:

☐ Pathology / Tissue reports	☐ Office notes	☐ Imaging studies
☐ Operative reports	☐ Medications list	☐ Demographics
☐ Scope reports	☐ Mammogram report and films	☐ Insurance information
☐ X-ray / Ultrasound reports	☐ HIV test results	☐ Progress notes
☐ Cardiac clearance reports	☐ Drug screen results	☐ Ancillary / Miscellaneous reports

To release information:

☐**Email**: info@keywestsurgicalgroup.com ☐**Fax**: (844) 697-0717 ☐**Phone:** (305) 294-1041

☐**Mailing Address:** Key West Surgical Group 3136 Northside Drive. Key west, FL 33040

Signature:

Patient or legal representative: _____ Date: _____

Print name of person signing: _____
(if not the patient)

Relationship to patient: _____

KEY WEST SURGICAL GROUP
3136 Northside Drive, Key West, FL 33040
www.keywestsurgicalgroup.com

Phone: 3055-294-1041
Fax: 305-293-0990
Email: info@keywestsurgicalgroup.com

COLONOSCOPY FINANCIAL POLICY

Thank you for choosing *Key West Surgical Group* for your medical care. This patient financial policy has been developed to help our patients understand their financial responsibilities regarding their healthcare benefits. Please read carefully and sign at the bottom. We suggest you keep a copy of this policy for your reference should any questions arise regarding your bill.

The Affordable Care Act allows for preventative services, such as colonoscopies, to be covered at no cost to the patient. However, there are strict guidelines used to determine which category of colonoscopy can be defined as a screening/preventive service. These guidelines may exclude those patients with; any current gastrointestinal signs and symptoms, history of gastrointestinal disease, a personal or family history of colon polyps or colon cancer, from taking advantage of the procedure at no cost. In cases like these, patients may be required to pay co-pays, co-insurance and/or deductibles.

Please note: Although your primary care provider may refer you for a "screening" colonoscopy, you may not qualify for the "preventive/screening" benefit under your insurance plan. There are three colonoscopy categories:

1. Diagnostic/Therapeutic Colonoscopy: The patient has past and/or present gastrointestinal symptoms, polyps, or gastrointestinal disease. Usually subject to copay, coinsurance and/or deductible.

2. Surveillance/High Risk Screening Colonoscopy: The patient is asymptomatic (no gastrointestinal symptoms either past or present) or has a personal history of gastrointestinal disease, colon polyps, and/or cancer. Patients in this category are required to undergo colonoscopy surveillance at shortened intervals. These procedures may be subject to copay, coinsurance and/or deductible.

3. Preventative Screening Colonoscopy: The patient is asymptomatic (no gastrointestinal symptoms either past or present), is 5O years or older, has no personal or family history of gastrointestinal disease, colon polyps, and/or cancer. The patient has not undergone a colonoscopy within the last 10 years. If these guidelines are met, may be covered at 100% under your plan.

NOTE: Having had a colonoscopy in the past makes a difference in how your insurance plan covers future colonoscopies. If you have a colonoscopy before insurance guidelines allow and *Key West Surgical Group* is unaware of this, you will be responsible for the fees associated with the procedure. **

The colonoscopy procedure has three, possibly 4 separately billable components that consist of:

1. The professional services of the surgeon (Key West Surgical Group). Including the fee for the colonoscopy and removal of polyps if applicable.
2. The professional & medical services of the anesthesiologist.
3. The facility fee (Surgery Center of Key West or Lower Keys Medical Center).
4. Pathology/lab fees (if you have polyps removed or biopsies taken).

As a courtesy, our office will check with your health insurance plan to obtain a cost **estimate** and see if a pre-certification is required. We require pre-payment on all procedures and you will be asked to provide this at least one week prior to your procedure. We can never guarantee how your health insurance will pay for your services. It is always a good idea to call your insurance and understand your benefits and your health insurance expectations.

I have read and fully understand the above information:

Name of Patient: _____ Signature: _____ Date: _____

If patient is unable to sign
Name of person authorized to sign:_____ Relationship to patient: _____