

Ohio Valley Colon & Rectal Surgeons, Inc.

James Waller, MD
Deane Smith, MD
Syam Chilukuri, MD
Santiago Arruffat, MD

TODAY'S DATE: _____
PT. NAME: _____
CHART#: _____

SOCIAL HISTORY:

PATIENT NAME _____ BIRTH DATE _____ AGE _____ SEX _____
ADDRESS (Street) _____ SOCIAL SECURITY # _____ - _____ - _____
(PO Box) _____
(City) _____ (State) _____ (Zip) _____
PHONE (home) _____ PHONE (work) _____
E-MAIL (home) _____ E-MAIL (work) _____
CELL PHONE _____

MARITAL STATUS (circle one) S M D W RACE (optional) _____

Patient's Employer (or retired from) _____

Patient's Employer's ADDRESS _____

IF MARRIED / IF A MINOR CHILD

Spouse/Parent's NAME _____ BIRTH DATE _____ AGE _____ SEX _____
ADDRESS (Street) _____ SOCIAL SECURITY # _____ - _____ - _____
(City) _____ (State) _____ (Zip) _____
PHONE (home) _____ PHONE (work) _____
CELL PHONE _____

Spouse/Parent Employer _____

Spouse/Parent Employer's ADDRESS _____

INSURANCE HISTORY:

Primary Insurance Co. _____ Secondary Insurance Co. _____
Member Name: _____ Member Name: _____

Person Responsible for Bill _____

OHIO VALLEY COLON AND RECTAL SURGEONS, INC

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APPT. DATE _____ TIME _____
TODAY'S DATE _____
DR. W / S / C / A CHART # _____

PATIENT MEDICAL HISTORY

Please complete ALL sections and SIGN. May use "N/A" if not applicable.

NAME _____ BIRTH DATE _____ AGE _____ SEX _____

REFERRING PHYSICIAN

(First name, Last name, Address, Phone #)

FAMILY PHYSICIAN

(First name, Last name, Address, Phone #)

OCCUPATION/SCHOOL _____ GRADE IN SCHOOL _____

DO YOU SMOKE ___yes ___no how many packs a day? _____ For how many years? _____

DO YOU DRINK ALCOHOL? ___yes ___no how often? _____ how much? _____

REASON FOR TODAY'S VISIT: _____

MEDICAL HISTORY:

HEIGHT: _____ WEIGHT: _____ BP: _____ Pulse: _____ Resp: _____ Temp: _____

(Check all that apply to YOU, not your family)

yes no

- lung disease/asthma
high blood pressure
cancer, location
heart disease
stroke
heart attack
Cardiologist
arhythmia
diabetes, insulin dependent
diabetes, not insulin dependent
diverticulosis
irritable colon
stomach ulcers
arthritis, rheumatoid, lupus
heart murmur

yes no

- psychological problems/depression
degenerative muscle/nerve disease
seizures/convulsions
gallbladder disease (now)
kidney/bladder infections
venereal disease, hepatitis, AIDS
bleeding disorder/hemophilia
thyroid trouble
blood clots
artificial joints
tuberculosis
history of polyps
Prosthetic heart valve
Mitral valve prolapse

PREGNANT: _____ (yes)

Other Medical Illness: _____

Do you have a pacemaker? _____

Do you have an internal defibrillator? _____

Medical History PAGE 2

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PREVIOUS OPERATIONS

Operation	Date	Operation	Date
<input type="checkbox"/> Prostate surgery	_____	<input type="checkbox"/> Joint replacement	_____
<input type="checkbox"/> Open heart surgery	_____		
<input type="checkbox"/> Hysterectomy		Other Operations	Date
_____		<input type="checkbox"/> _____	_____
<input type="checkbox"/> Complete	_____	_____	
<input type="checkbox"/> Partial	_____	<input type="checkbox"/> _____	_____
<input type="checkbox"/> Cancer	_____	_____	
<input type="checkbox"/> Colon surgery	_____	<input type="checkbox"/> _____	_____
<input type="checkbox"/> Polypectomy	_____	_____	
<input type="checkbox"/> Hernia repair	_____	_____	

HAVE YOU HAD PREVIOUS COLON EXAMS:

_____ Flexible Sigmoidoscopy	Date _____	Doctor _____
_____ Colonoscopy	Date _____	Doctor _____
_____ Barium Enema	Date _____	Doctor _____
_____ Other _____	Date _____	Doctor _____

FAMILY HISTORY: Please list your family history. Yes if living, No if deceased. Please list the family member's present age or age at death.

	Living? YES/ NO	Age (yrs)	History of Colon or Rectal cancer? or Rectal polyps?	List Other Medical Conditions (Diabetes, heart disease, or cause of death)
FATHER	_____	_____	_____	_____
MOTHER	_____	_____	_____	_____
BROTHER	_____	_____	_____	_____
	_____	_____	_____	_____
SISTER	_____	_____	_____	_____
	_____	_____	_____	_____
CHILDREN	_____	_____	_____	_____
	_____	_____	_____	_____
OTHER	_____	_____	_____	_____
	_____	_____	_____	_____

To the best of my knowledge, all the information listed on my medical history form and medications records are correct. **Patient Signature** _____ **Date** _____

I have reviewed with the patient/patient representative
Physician Signature _____ **Date** _____

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EMERGENCY CONTACT PERSON/who does not live with you:

Name _____

Phone _____

Relationship _____

Notification of Ownership

I acknowledge that I have been informed of my physician's joint ownership in the management company associated with St. Mary's Surgicare (a St. Mary's outpatient department) providing excellent cost-effective care and convenience. I have been informed **I am free to request services be scheduled at another facility**, should I prefer.

Authorization to Treat

I authorize examination and treatment by Ohio Valley Colon & Rectal Surgeons, Inc. (OVCS), and providers employed by OVCS.

Acknowledgement of this Document

By my signature, I acknowledge that I have read and received the *Notification of Ownership*, and *Authorization to Treat*, as contained on this form. **Notice of Privacy Practices available upon request or visit our website at www.colonsurgeons.com.**

Patient or authorized representative signature

Date

Limited Patient Authorization for Disclosure of Protected Health Information

Please print all information. Form must be signed and dated.

Patient Name: _____

Social Security Number: _____ Date of Birth: _____

Purpose of request (who will be authorized to receive information) – I authorize the practice to disclose or provide protected health information, about me, to: (please identify a family member or friend who will receive the information):

Entity Providing Information:

Person Receiving Information:

Ohio Valley Colon & Rectal Surgeons, Inc.

Name: _____

Drs. Waller, Smith, Chilukuri, & Arruffat

801 St. Mary’s Dr. West, Suite 300

Address: _____

Evansville, IN 47714

City, State, Zip: _____

812-477-9241

Phone: _____

Fax: 812-474-6708

Fax: _____

Description of information to be disclosed – I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above: (please provide a written description of the information to be disclosed):

- Entire patient record, including but not limited to: office notes; lab results; x-rays; hospital, nursing home, home health, hospice, and other physician records; record of HIV and communicable disease testing; record of mental health or substance abuse treatment; and financial history report (previous 3 years only).
- Office notes, labs and x-rays only.
- Only send the following: _____

Purpose of disclosure (please check the purpose of the disclosure or check patient request):

- Patient Request
- Other (please specify): _____

Expirations or termination of authorization: This authorization will expire in one year from date of your signature below, unless you specify an earlier termination. You must submit a new authorization after the expiration date to continue the authorization. You have the right to terminate this authorization at any time. You must notify our privacy manager, in writing, if you decide to terminate the authorization prior to the normal expiration date.

(Please list an earlier expiration if less than one year): _____

Right to revoke or terminate: As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager.

Non-Conditioning statement: The practice places no condition to sign this authorization on the delivery of healthcare or treatment.

Redisclosure: We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Ruse and will no longer be the responsibility of the practice.

Patient Signature

Date

Copies of signed authorizations are available upon request.



Payment Policy and Agreement

Patient: _____

Chart #: _____

Dr: Waller Smith Chilukuri Arruffat

Our commitment to our patients is to provide quality, affordable healthcare. In order to succeed we need your assistance and understanding of our payment policy.

You will be financially responsible for all charges on your account with *Ohio Valley Colon & Rectal Surgeons*, including but not limited to, co-payments, co-insurance, non-covered services, and deductibles. **Insurance co-payments are due at check-in on the date of service. If you are unable to pay co-payment, you will be asked to reschedule your appointment.**

As a courtesy, *OVCRS* will contact your insurance company to obtain Authorization, or Pre-certifications for procedures scheduled by our office. Please remember that authorization or pre-certification **does not guarantee coverage with your insurance**. It is the patient's responsibility to contact the insurance carrier prior to all services rendered, for determination of benefits and to know and understand the expected out of pocket expenses you may occur.

Patients with high deductible plans, \$1000 or more, will be expected to pay a portion of approved fees prior to services rendered.

Routine screening procedures will be expected to pay ½ of approved charges and non-routine procedures will be expected to pay 1/3 of approved charges. You will be contacted by our business office if prepayment is required. There will be facility charges in addition to the physician's fee for all procedures done outside *OVCRS* office. **The patient is responsible for making separate arrangements with the facility for payment of those charges.**

Uninsured/self-pay patients will be asked to make payment in full unless prior arrangements are made in advance of services rendered. Please ask to speak to a member of our insurance staff to inquire about payment options that are available. **We do offer some interest free financing options for patients that qualify.**

Disability/Family Medical Leave Act forms will be filled out for the **Patient** at no cost. Any additional forms for patient or family members will be charged a fee of \$5.00 per form.

We accept cash, check, MasterCard and Visa. You will receive a monthly statement on your account for any balance due and payment is expected upon receipt of statement. If payment is not received on account within 60 days, collection process may be initiated.

Payment Agreement

As the Patient or Patient Authorized Representative and Responsible Party, I hereby understand the payment policy and agreement set forth by *OVCRS*. I also request that payment of authorized insurance benefits (including, but not limited to Medicare, Medicaid, HMO, PPO, BC/BS and Workers Compensation) be made on my behalf to *OVCRS* for any services furnished to me by physicians or employees of *OVCRS*. I authorize any holder of medical or other information about me to release to my insurance company and its agents any information needed to determine these benefits or benefits for related services. I request that any other insurance benefits be paid directly to *OVCRS*. I authorize *OVCRS* to submit claims to my insurance carriers or their intermediaries for all services rendered by *OVCRS*. I authorize the release of any information required to process any claims. **Notice of Privacy Practices available upon request or visit our website at www.colonsurgeons.com.**

I understand that I am financially responsible for all balances regardless of insurance coverage, if any, subject to Federal Law concerning payment for services provided to Medicare beneficiaries. I also agree to be responsible for reasonable attorney's fees, court costs and other collection expenses incurred by *OVCRS* in connection with collection of amounts due.

Patient Name (print)

Patient Signature/Patient Authorized Representative

Date: _____

White copy (Office use)

Yellow copy (Patient)