ColoRectal
SPECIALISTS

Sign me up for my FollowMyHealth (FMH)

Patient Portal with ColoRectal Specialists.

Full Name:____

Date of Birth:__________________ Zip Code:______________

Email:____

[ ] @gmail.com [ ] @yahoo.com

[ ] @hotmail.com [ ] @att.net

[ ] @sbcglobal.net [ ] @aol.com

[ ] Other (Please list)__________________________________

Cell Phone:____

I herewith authorize ColoRectal Specialists, a division of Signature Medical Group, to create my FollowMyHealth (FMH) patient portal account and agree to all of its terms and conditions.

Patient Signature:______________________________________

Date:__________________

ColoRectal Specialists
a division of Signature Medical Group

PATIENT INFORMATION (PLEASE PRINT)

Name ____________________ ☐ Male ☐ Female
(Last) (First) (MI)
Student ☐ Full ☐ Part time

Address ____________________
(Street) (City) (State) (Zip)

Telephone (h)__________ (w) __________ (cell) __________

SS# __________ DOB __________ AGE ____ (Marital Status) ☐ Single ☐ Married ☐ Widow ☐ Divorced

Employer ____________________ ☐ Full time ☐ Part time ☐ Retired

Spouse's Name__________ Spouse's Work/Cell Phone__________

Closest relative not living with you:

Name__________ Relation__________ Daytime Phone__________

Physician Information:

Referred By:__________ Primary Physician __________

Gastroenterologist__________ Surgeon __________

Other doctors (name and specialty)____________________

Insurance Information: (PRIMARY)

Insurance Co. __________ ID# __________ Group#__________

Insured's Name __________ DOB __________

Insured's Address __________ Phone (h) __________ (w) __________

Insured's SS# __________ Relation to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Information: (SECONDARY)

Insurance Co. __________ ID# __________ Group#__________

Insured's Name __________ DOB __________

Insured's Address __________ Phone (h) __________ (w) __________

Insured's SS# __________ Relation to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other

ALL CO-PAYMENTS ARE EXPECTED TO BE PAID AT TIME OF VISIT

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES FOR SERVICES TO ME, INCLUDING THE BALANCE REMAINING AFTER PAYMENT OF POSSIBLE INSURANCE BENEFITS. IF MY ACCOUNT IS 90 DAYS OR MORE PAST DUE, I WILL BE LIABLE FOR ANY AND ALL EXPENSES RELATED TO COLLECTING MY DEBT; WHICH MAY INCLUDE LATE CHARGES, BILLING, COLLECTION AGENCY AND/OR LEGAL FEES. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO SIGNATURE MEDICAL GROUP, INC. FOR PROFESSIONAL SERVICES RENDERED. I AUTHORIZE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY CLAIMS. I UNDERSTAND THAT YOU MAY BE TRANSMITTING MY MEDICAL RECORDS ELECTRONICALLY AND AUTHORIZE YOU TO DO SO. IF THEY ARE RECEIVED BY ANOTHER PARTY IN ERROR, I ABSOLVE SIGNATURE MEDICAL GROUP, INC. OF ANY AND ALL LIABILITY RELATING TO SUCH SUBMISSION OF SAID RECORDS.

IN ADDITION, I AUTHORIZE SIGNATURE MEDICAL GROUP, INC. TO OBTAIN ANY MEDICAL RECORDS NECESSARY FROM ANY HEALTH CARE PROVIDER OR INSTITUTION INVOLVED WITH MY HEALTH CARE.

Patient Signature ____________________ ***Date*** __________

INT106SMG
AUG-15

NAME ______________________________
(LAST) **(FIRST)** **(MI)**

Reason for Visit ______________________ **Date** __________

How often do you move your bowels:_____ times/day

_____ times/wk

Has this changed in the last year? ☐ Yes ☐ **No**

Please check if you have any of the following:
- ☐ Anal or rectal **bleeding**
- ☐ Anal, rectal or abdominal **pain**
- ☐ **Hemorrhoids**
- ☐ Anal **itching** or **burning**
- ☐ Problems **controlling** bowels (fecal incontinence)

☐ **None**

Have **YOU** ever been diagnosed with:
- ☐ Colon polyps
- ☐ Chronic Ulcerative Colitis
- ☐ Crohn's Disease
- ☐ Colon Cancer
- ☐ Diverticular Disease

☐ **None**

Have you EVER had (please list all)

☐ **Never had surgery**

- ☐ Rectal Surgery type/when ______________
- ☐ Abdominal surgery type/when ______________
- ☐ Cardiac surgery type/when ______________
- ☐ Other type/when ______________

____

My LAST colonoscopy was ☐ **Never had one**

Where ______________________________

When ______________ Result ______________

Has your mother(**M**), father(**F**), brother(**B**), or sister(**S**) had:
circle all that apply:

Colon or rectal cancer?	☐ Yes	☐ **No**	M F B S
Colon or rectal polyps?	☐ Yes	☐ **No**	M F B S
Crohn's Disease or Ulcerative Colitis?	☐ Yes	☐ **No**	M F B S
Other Colitis?	☐ Yes	☐ **No**	M F B S

Do you suffer from (check all that apply):
- ☐ Anorexia (very poor appetite)
- ☐ Fever
- ☐ Chills
- ☐ Weight loss ☐ Weight gain
  ____ lbs. over _____ week(s)/month(s)
- ☐ Calf pain
- ☐ Seizures
- ☐ Anxiety
- ☐ Depression
- ☐ Urinary frequency
- ☐ Abnormal bleeding/bruising
- ☐ Dysuria (painful urination)
- ☐ Impotence
- ☐ Blindness
- ☐ Shortness of breath with exercise
- ☐ Shortness of breath without exercise
- ☐ Angina (chest pain)

- ☐ Anemia (low blood count)
- ☐ Anorectal abscess
- ☐ Anorectal fistula
- ☐ Atrial fibrillation
- ☐ Cardiac stents
- ☐ Chronic kidney failure
  Are you on Dialysis? ☐ Yes ☐ **No**
- ☐ COPD/Emphysema
- ☐ Congestive heart failure in the last 30 days
- ☐ Diabetes ☐ Insulin ☐ Oral ☐ Diet
- ☐ GERD (acid reflux)
- ☐ High blood pressure
- ☐ Heart attack – when ___________
- ☐ Pulmonary embolism
- ☐ Prostate cancer
- ☐ Sleep apnea
- ☐ Stroke
- ☐ Other______________________

____

☐ **None of the above**

☐ Smoke ____ pk/day ☐ Never smoked ☐ Stopped greater than 1 year ago ☐ Recently stopped

☐ No alcohol use Currently drink: ☐ **beer** ____ cans/day ____ cans/wk ☐ **alcohol** ____ oz/day ____ oz/wk

Are you ☐ fully **independent** ☐ **partially dependent** on others ☐ **completely dependent** on others?

Date of your last FLU shot?______________ ☐ **Never** Date of your last Pneumonia Vaccine?______________ ☐ **Never**

Patient Signature ______________________________

INT101SMG
Jun-17

NAME ______________________________ **Date**______________
(LAST) (FIRST) (MI)

Race (check one)
- ☐ Caucasian (not Hispanic/Latino)
- ☐ Black/African American
- ☐ Asian
- ☐ Hispanic/Latino (all races)
- ☐ Indian
- ☐ Multiracial (more than one race)
- ☐ Other ______________
- ☐ Unknown/not reported

Please check your primary language:
- ☐ English
- ☐ Bosnian
- ☐ Korean
- ☐ Russian
- ☐ Chinese
- ☐ Spanish/Castillian
- ☐ Hindi
- ☐ Other ______________
- ☐ Unknown/not reported

Ethnicity (check one)
- ☐ Bosnian
- ☐ Indian
- ☐ Hispanic
- ☐ English
- ☐ German
- ☐ Greek
- ☐ Irish
- ☐ Jewish
- ☐ Mixed (more than one)
- ☐ Other ______________
- ☐ Unknown/not reported

List daily medications and medical problem being treated
☐ **None**

drug	dosage	medical problem
drug	dosage	medical problem
drug	dosage	medical problem
drug	dosage	medical problem
drug	dosage	medical problem
drug	dosage	medical problem
drug	dosage	medical problem
drug	dosage	medical problem
drug	dosage	medical problem

Drug allergies:______________ ☐ **None**

Reaction?______________

Pharmacy information:

Preferred:

Name ______________

Address ______________

Phone ______________

Alternate:

Name ______________

Address ______________

Phone ______________

This information is required by the government. Thank you.

Patient Signature ______________________

INT102SMG
Jun-17

David Schuval, M.D.
Board Certified

Ralph Silverman, M.D.
Board Certified

Authorization to Release Medical Information

(The patient or legal guardian of patient should fill out this form)

PLEASE READ THE FOLLOWING QUESTIONS CAREFULLY AND SIGN AT THE BOTTOM:

1. Does your household have an answering machine? ☐ YES ☐ NO
   If yes, may we leave a message on it? ☐ YES ☐ NO

2. May we leave a message at the patients place of employment to contact this office? ☐ YES ☐ NO

3. May we discuss the patient's medical condition with others who may contact the office/physicians regarding the patient? ☐ YES ☐ NO

   If yes, please list the name(s) and relationship to the patient:

Name of person (Please print)	Relationship/**phone #**
______________________________	______________________
______________________________	______________________
______________________________	______________________

Please list any information from your chart at Signature Medical Group, Inc. you would not wish to have disclosed:

____
____
____
____

I give permission to Signature Medical Group, Inc. to release information (verbal or written) regarding myself/or________________________'s medical condition, and/or information regarding treatment to the above named person(s) only for the purpose of medical management.

______________________________ ______________________________
Patient or Legal Guardian's signature Date

This release may be rescinded at any time in writing.

Signature Medical Group, Inc. cannot guarantee your request will be honored to the fullest. In the event of emergency, Signature Medical Group, Inc. will disclose information related to your emergency condition.

12345 West Bend Drive Suite 303 St. Louis, MO 63128 Phone: (314) 849-1811 Fax: (314) 849-7470

www.crsstl.com

CONSENT FOR TREATMENT, RELEASE OF INFORMATION, ASSIGNMENT OF BENEFITS, AND FINANCIAL RESPONSIBILITY

Patient Name: ______________________________ DOB: ______________

SS#: ____________________________________

CONSENT

I hereby consent to the administration of treatment deemed necessary by Signature Medical Group, Inc. its employees, associates and assistants to provide medical care, tests, procedures, drugs or drug products, services and supplies considered advisable by my physician.

I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as a result of medical treatments, diagnostic procedures or examinations by Signature Medical Group, Inc. . I am aware that, except in limited situations (such as in a medical emergency), I will be requested to give separate consents should I need to undergo surgery or other invasive procedures.

ASSIGNMENT OF INSURANCE BENEFITS

In consideration of any and all medical services, care, and supplies, furnished by Signature Medical Group, Inc. , I hereby authorize direct payment to Signature Medical Group, Inc. of all insurance benefits (including Medicare and benefits), which are now or which shall become due and payable to me. In addition, I hereby authorize direct payment to Signature Medical Group, Inc. of all insurance benefits applicable to medical and/or surgical services rendered by physicians for whom Signature Medical Group, Inc. is authorized to charge and bill. If my physician and/or other physicians associated with Signature Medical Group, Inc. or whom Signature Medical Group, Inc. may designate accepts insurance assignment, then I hereby authorize my insurance benefits to be paid directly to those physicians.

MEDICARE/TRICARE/VA INSURANCE BENEFITS

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the release of medical or other information to the Social Security Administration or its intermediaries or carriers concerning this or a related Medicare claim filed by Signature Medical Group, Inc. . I request that payment of authorized benefits be made on my behalf I understand that I am responsible for the Part B deductible for each year, the remaining co-insurance and any other non-covered personal charges. I (or my representative) certifies that I or he/she has read (or if the patient/representative is unable to read has had the form read to him/her) and understands and accepts the above and further certifies that I am the patient, or am duly authorized on behalf of the patient to execute such an agreement.

FINANCIAL RESPONSIBILITY

In accordance with the above terms and in consideration of the services rendered to the patient designated herein at my request for this occasion of service, I understand that I am financially responsible for all charges for services to me, including the balance remaining after payment of possible insurance benefits. If my account is 90 days or more past due, I will be liable for any and all expenses related to collecting my debt; which may include late charges, billing, collection agency and/or legal fees.

By signing the financial responsibility statement, the patient and guarantors acknowledge and agree they are responsible for payment of billed charges rendered in any case in which payment may be denied by the health maintenance organization (or preferred provider organization) because of a failure to comply with such coverage requirements or for any other reason.

RELEASE OF INFORMATION

I hereby authorize Signature Medical Group, Inc. and my treating physicians to release by electronic means or otherwise, protected health information concerning my care, including copies of my medical records, to the following:

a. Any health professionals involved in my care for the purpose of facilitating the continuity of my medical care.
b. Any person or entity responsible for, or any person or entity acting as an agent for the party responsible for payment, including third party payors, self-insurers, worker's compensation carriers and governmental agencies, payment for the medical services rendered to me at Signature Medical Group, Inc. , by employees of Signature Medical Group, Inc. .
c. Any federal, state or other governmental or quasi-governmental agencies or other such parties as required by law for purposes of reporting, or for purposes of determining eligibility in government sponsored benefit programs.
d. Any person or entity participating in quality studies, utilization review or similar studies of the care rendered by Signature Medical Group, Inc. and/or their physicians.

I acknowledge that my medical information may include information relative to alcohol abuse, drug abuse; psychological or psychiatric conditions, Human Immunodeficiency Virus (HIV), and/or Acquired Immunodeficiency Syndrome (AIDS).

I acknowledge that this consent for release of information has no expiration date and is valid for the release of medical records and billing information at any time.

I authorize release of information as stated above unless one of the options below is selected.

☐ I do not authorize release of information.

☐ I am limiting and/or restricting the release of such information (e.g., release to only immediate family or release to identified individuals), as noted:

Signature Medical Group, Inc. agrees/does not agree to limitations/restrictions ____________________

NOTICE OF PRIVACY PRACTICES

I acknowledge that prior to signing this authorization form, I have a right to request and inspect the Signature Medical Group, Inc. Notice of Privacy Practices ("Notice") which provides additional information about how the Signature Medical Group, Inc. may use and disclose my protected health information. I understand that, as provided in the Notice, the terms of the Notice may change. I further understand that if the terms of the Notice change, I may request a copy of the revised Notice by contacting the office manager of Signature Medical Group, Inc. .

I acknowledge that I have the right to request that Signature Medical Group, Inc. . restrict how my protected health information is used or disclosed for purposes of my medical treatment and payment. I understand Signature Medical Group, Inc. is not required to agree to my requested restrictions. Should Signature Medical Group, Inc. agree to any restrictions, however, it is bound by its agreement to do so.

I further acknowledge that I have the right to revoke my authorization permitting Signature Medical Group, Inc. to use or disclose my protected health information for purposes of my medical treatment and payment to the extent that Signature Medical Group, Inc. has not done so in reliance on my prior authorization.

I acknowledge that I have read this form and understand its contents fully. I agree to obey the rules and regulations of Signature Medical Group, Inc. and understand that these rules and regulations apply not only to patients of Signature Medical Group, Inc. , but to the patient's authorized representatives as well. A copy of this form shall have the same force and effect as the original.

The undersigned is the patient, the patient's legal representative, or is authorized by the patient to execute this form and accepts its terms.

____
Print Patient Name

____________________________________ ____________________
Signature of patient Date

____________________________________ ____________________
Signature of Legal or Authorized Representative/ Guarantor Relationship

RELEASE OF INFORMATION

I hereby authorize Signature Medical Group, Inc. and my treating physicians to release by electronic means or otherwise, protected health information concerning my care, including copies of my medical records, to the following:

a. Any health professionals involved in my care for the purpose of facilitating the continuity of my medical care.
b. Any person or entity responsible for, or any person or entity acting as an agent for the party responsible for payment, including third party payors, self-insurers, worker's compensation carriers and governmental agencies, payment for the medical services rendered to me at Signature Medical Group, Inc. , by employees of Signature Medical Group, Inc. .
c. Any federal, state or other governmental or quasi-governmental agencies or other such parties as required by law for purposes of reporting, or for purposes of determining eligibility in government sponsored benefit programs.
d. Any person or entity participating in quality studies, utilization review or similar studies of the care rendered by Signature Medical Group, Inc. and/or their physicians.

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The undersigned is the patient, the patient's legal representative, or is authorized by the patient to execute this form and accepts its terms.

____
Print Patient Name

______________________________ ______________
Signature of patient Date

______________________________ ______________
Signature of Legal or Authorized Representative/ Guarantor Relationship

CONSENT FOR TREATMENT, RELEASE OF INFORMATION, ASSIGNMENT OF BENEFITS, AND FINANCIAL RESPONSIBILITY

Patient Name: ______________________________ DOB: ______________

SS#: ______________________________

CONSENT

I hereby consent to the administration of treatment deemed necessary by Signature Medical Group, Inc. its employees, associates and assistants to provide medical care, tests, procedures, drugs or drug products, services and supplies considered advisable by my physician.

I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as a result of medical treatments, diagnostic procedures or examinations by Signature Medical Group, Inc. . I am aware that, except in limited situations (such as in a medical emergency), I will be requested to give separate consents should I need to undergo surgery or other invasive procedures.

ASSIGNMENT OF INSURANCE BENEFITS

In consideration of any and all medical services, care, and supplies, furnished by Signature Medical Group, Inc. , I hereby authorize direct payment to Signature Medical Group, Inc. of all insurance benefits (including Medicare and benefits), which are now or which shall become due and payable to me. In addition, I hereby authorize direct payment to Signature Medical Group, Inc. of all insurance benefits applicable to medical and/or surgical services rendered by physicians for whom Signature Medical Group, Inc. is authorized to charge and bill. If my physician and/or other physicians associated with Signature Medical Group, Inc. or whom Signature Medical Group, Inc. may designate accepts insurance assignment, then I hereby authorize my insurance benefits to be paid directly to those physicians.

MEDICARE/TRICARE/VA INSURANCE BENEFITS

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the release of medical or other information to the Social Security Administration or its intermediaries or carriers concerning this or a related Medicare claim filed by Signature Medical Group, Inc. . I request that payment of authorized benefits be made on my behalf I understand that I am responsible for the Part B deductible for each year, the remaining co-insurance and any other non-covered personal charges. I (or my representative) certifies that I or he/she has read (or if the patient/representative is unable to read has had the form read to him/her) and understands and accepts the above and further certifies that I am the patient, or am duly authorized on behalf of the patient to execute such an agreement.

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In accordance with the above terms and in consideration of the services rendered to the patient designated herein at my request for this occasion of service, I understand that I am financially responsible for all charges for services to me, including the balance remaining after payment of possible insurance benefits. If my account is 90 days or more past due, I will be liable for any and all expenses related to collecting my debt; which may include late charges, billing, collection agency and/or legal fees.

By signing the financial responsibility statement, the patient and guarantors acknowledge and agree they are responsible for payment of billed charges rendered in any case in which payment may be denied by the health maintenance organization (or preferred provider organization) because of a failure to comply with such coverage requirements or for any other reason.

SIGNATURE MEDICAL GROUP, INC.

Acknowledgment of Receipt of Notice of Privacy Practices

I, ____, have received a copy of Signature Medical Group, Inc.'s updated Notice of Privacy Practices.

____
Signature of patient or parent/legal guardian/legally responsible person

____
Description of relationship to the patient

____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual/Representative refused to sign the form
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

____

____

____

09.23.2013