

PATIENT INFORMATION (PLEASE PRINT)

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

Address _____
(Street) (City) (State) (Zip)

Telephone (h) _____ (w) _____ (cell) _____

Please check your preferred method of contact: Home Work 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** _____



**ColoRectal
SPECIALISTS**
A DIVISION OF SIGNATURE MEDICAL GROUP

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: _____

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 None

Anal **itching** or **burning**

Problems **controlling** bowels (fecal incontinence)

Have **YOU** ever been diagnosed with:

Colon polyps

Chronic Ulcerative Colitis

Crohn's Disease None

Colon Cancer

Diverticular Disease

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 _____

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 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





**ColoRectal
SPECIALISTS**

**SIGNATURE
MEDICAL GROUP**

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



**ColoRectal
SPECIALISTS**



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Board Certified

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Relationship/phone #

_____	_____
_____	_____
_____	_____

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

I give permission to Signature Health Services, 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.

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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 Health Services, 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 Health Services, 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 Health Services, Inc. , I hereby authorize direct payment to Signature Health Services, 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 Health Services, Inc. of all insurance benefits applicable to medical and/or surgical services rendered by physicians for whom Signature Health Services, Inc. is authorized to charge and bill. If my physician and/or other physicians associated with Signature Health Services, Inc. or whom Signature Health Services, 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 Health Services, 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 Health Services, 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 Health Services, Inc. , by employees of Signature Health Services, 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 Health Services, 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 Health Services, 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 Health Services, Inc. Notice of Privacy Practices ("Notice") which provides additional information about how the Signature Health Services, 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 Health Services, Inc. .

I acknowledge that I have the right to request that Signature Health Services, Inc. . restrict how my protected health information is used or disclosed for purposes of my medical treatment and payment. I understand Signature Health Services, Inc. is not required to agree to my requested restrictions. Should Signature Health Services, 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 Health Services, Inc. to use or disclose my protected health information for purposes of my medical treatment and payment to the extent that Signature Health Services, 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 Health Services, Inc. and understand that these rules and regulations apply not only to patients of Signature Health Services, 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



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)

