

**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** \_\_\_\_\_

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:**

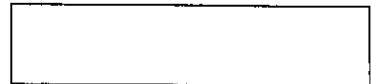
Name \_\_\_\_\_

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

## **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



**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)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**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: \_\_\_\_\_