Gulf Coast Surgical Group – 2439 Country Place Blvd. Suite #102 Trinity, FL 34655 P#727-845-1662 Fax#727-264-8869

First Name:	MI:	Last Name:	Suffix:
Address:	City:	State:	Zip:
SSN#:	DOB:	Age:	Marital Status:
Ethnicity:	Race:	Language:	
Phone#:	Cell#:	**Email**:	
Occupation:	Employer:		
Employer Phone#:	Employer Address:		
Primary Physician:	Phone#:		

Primary Insurance:	**Secondary Insurance:**
Policy Holder Name:	**Policy Holder Name:**
Policy Holder DOB:	**Policy Holder DOB:**
Policy Holder Address:	**Policy Holder Address:**

I Authorize discussion and release of my general medical condition and diagnosis (including billing & health care operations) with;

Name:	Relation:	Phone#:
Name:	Relation:	Phone#:

- DR. JARED C. FRATTINI PARTICIPATES WITH MEDICARE. HE CAN ACCEPT ASSIGNMENT ON ALL MEDICAL CLAIMS & WILL FILE THE CLAIM ELECTRONICALLY FOR YOU. YOU, THE PATIENT / BENEFICIARY WILL BE RESPONSIBLE FOR YOUR PART B DEDUCTIBLE NOT YET MET, & THE 20% CO- INSURANCE THAT MEDICARE DOES NOT PAY. ALL CO-PAYS & DEDUCTIBLES ARE COLLECTED BEFORE YOU SEE THE DOCTOR, & A RECEIPT WILL BE GIVEN AFTER SEEING THE DOCTOR. WE ACCEPT CASH, CHECKS, VISA, MASTERCARD & DISCOVER. A $35.00 CHARGE WILL BE ADDED FOR ANY RETURNED CHECKS.
- ALL HMO INSURANCE COMPANIES REQUIRE REFERRALS / AUTHORIZATIONS FROM YOUR PRIMARY CARE PHYSICIAN. IT IS YOUR RESPONSIBILITY TO OBTAIN THIS REFERRAL FOR YOUR APPOINTMENT. WE CAN NOT SEE YOU WITHOUT IT, SO PLEASE NOTIFY YOUR PRIMARY DOCTOR AS SOON AS YOUR APPOINTMENT IS MADE. YOU WILL BE RESPONSIBLE FOR ANY CHARGES DENIED DUE TO LACK OF AUTHORIZATIONS.
- A $30.00 CHARGE WILL BE COLLECTED FOR ALL WORK/DISABILITY FORMS. OUR OFFICE POLICY REQUIRES UP TO 10 BUSINESS DAYS FOR COMPLETION.
- A $30.00 CHARGE MAY BE BILLED TO YOU FOR ANY NO-SHOW APPOINTMENTS. PLEASE CALL OUR OFFICE AT LEAST 24 HOURS IN ADVANCE TO AVOID ANY UNNECESSARY CHARGES. IT IS THE PATIENT'S RESPONSIBILITY TO PROVIDE US WITH UP TO DATE & ACCURATE BILLING INFORMATION. FAILURE TO DO SO WILL RESULT IN YOU BEING HELD RESPONSIBLE FOR ALL CHARGES. IN THE EVENT THAT YOUR ACCOUNT IS PLACED WITH AN OUTSIDE COLLECTION AGENCY FOR COLLECTIONS, THE PATIENT / GUARANTOR WILL BE HELD RESPONSIBLE FOR ALL INCURRED EXPENSES.
- THE UNDERSIGNED AUTHORIZES DR. JARED C. FRATTINI TO COLLECT INSURANCE BENEFITS ON THEIR BEHALF, & TO RELEASE TO HIS / HER INSURANCE COMPANY ANY INFORMATION WHICH MAY BE A PART OF MY MEDICAL RECORDS.
- **I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF MY HIPPA PRIVACY NOTICE.**
- **I HERBEY GIVE DR. FRATTINI PERMISSION TO PERFORM ANY EXAMINATIONS, PROCEDURES OR TESTS THAT THEY DEEM NECESSARY FOR MY MEDICAL CONDITION.**
- **I GIVE DR. FRATTINI AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL RECORDS FROM OTHER PHYSICIANS & FACILITIES (VIA FAX, MAIL, EMAIL, TEXT MESSAGE, PHONE &/OR CELL PHONE) THAT PERTAIN TO MY MEDICAL CONDITION.**

-Have you appointed a durable power of attorney or heath care surrogate? Please list name of your POA or health care surrogate: _____ Do you have a living will? Yes / No	Yes ☐	No ☐
· **Is it okay to leave messages on your answering machine regarding appointments, test results, etc?**	Yes ☐	No ☐

Patients Signature:	Today's Date:

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Patient Name:	Date of Birth:
Drug Allergies:	

List of current medications or attach a list:

1	5
2	6
3	7
4	8

Pharmacy Name, Address, and Phone

Social History

Marital status:	Married		Single		Divorced		Widowed
Do you smoke?	Y or N	How many pack per day?		How many years?			
Do you drink?	Y or N	How many drinks per day?					
What is your occupation?							

Please List your Family History (medical problems, cancers, age at death, etc.)

Mother
Father
Siblings
Children

Please List your Medical Problems

1	4
2	5
3	6
other:	

Please List any surgical procedures you have had- Please list the month/year of procedure

1	Date:	4	Date:
2	Date:	5	Date:
3	Date:	6	Date:
other:			

Have you ever had a colonoscopy? **Y** or **N** If yes, when?	Physician:
Patient Signature:	Date:

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Gulf Coast Surgical Group

Review of Systems Form

Patient's Name:_____ **Date of Birth:**_____

Please <u>circle</u> the appropriate item in each category as to the symptoms you may have:

General: weight loss/gain fatigue fever chills night sweats other: _____

Skin: bruising rash ulcers nodules bleeding other: _____

Eyes: blurry vision tearing dry eyes spots other:_____

Nose/Ear/Mouth/Throat: hoarseness swallowing problems ringing in ears nose bleed other: _____

Cardio: palpitations chest pain lower leg edema heart attack other: _____

Lung: cough wheezing shortness of breath sputum asthma other: _____

GI: diarrhea constipation blood in stool bloating reflux nausea vomiting pain

Urine: pain frequency blood in urine incontinence other: _____

CNS: stroke seizure dizziness headache paralysis other: _____

Endocrine: hot/cold intolerance excessive thirst or urination other:_____

Muscle/Bones: joint pain stiffness back pain cramp other:_____

Psych: anxiety depression bipolar other: _____

Blood/Lymph: swollen glands anemia transfusions other:_____

Immune: Hepatitis A/B/C HIV other: _____

Patient's signature: _____ Date: _____

Gulf Coast Surgical Group

Jared C. Frattini, MD FACS
Colon and Rectal/General Surgery
2439 Country Place, Suite 102 • Trinity, FL 34655
Phone: 727-845-1662 / Fax: 727-264-8869

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ DOB: _____

Previous Name if applicable: _____ SSN: _____

I request/authorize the following physicians: _____

_____

_____

to release my healthcare information to Gulf Coast Surgical Group for:

NAME: Dr. Jared C. Frattini

FAX: 727-264-8869

This request and authorization applies to:

○ All healthcare information

○ Other _____

Patient Signature: _____Date:_____

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We, the staff at Gulf Coast Surgical Group thank you for choosing us as your healthcare provider. We consider it a privilege to serve your needs and we look forward to doing so. We are committed to providing you with the highest level of care and to building a successful provider- patient relationship with you and your family.

We believe your understanding of our patients' financial responsibility is vital to that provider- patient relationship and our goal is to not only inform you of the provisional aspects of that financial policy but also to keep the lines of communication open regarding them. If at any time you have questions or concerns regarding our fees, policies, or responsibilities, please feel free to contact the office manager, at 727-845-1662 extension, 204. We believe this level of communication and cooperation will allow us to continue to provide quality service to all of our valued patients.

Please understand that payment for services is an important part of the provider- patient relationship. If you do not have insurance, proof of insurance, or participate in a plan that will not honor an assignment of insurance benefits, payment for services will be due at time of service unless a payment arrangement has been approved in advance by our staff.

We make payment as convenient as possible by accepting cash, money order, Mastercard, American Express, Visa and in-state checks. A $35.00 service fee will be charged for all returned checks.

Attorney and/or Collection Fees

If your account becomes delinquent and is submitted to a collection agency, you will be responsible for an additional 40% collection fee.

Insurance

Please remember that your insurance policy is a contract between you and your insurance carrier. We will, as a courtesy, bill your insurance and help you receive the maximum allowable benefit under your policy. We have found that patients who are involved with their claims process are more successful at receiving prompt and accurate payment services from their insurance carrier. We do expect patients to be interactive and responsible for communicating with your insurance carrier on any open claims.

It is your responsibility to provide all necessary insurance eligibility, identification, authorization, and referral information and to notify our office of any information changes when they occur. Even a preauthorization of services does not guarantee payment from your insurance carrier. We also require photo identification when accepting insurance information.

It is the patients responsibility to know if our office is participating or non-participating with their insurance plan. Failure to provide all required information may necessitate patient payment for all charges. When insurance is involved, we are contractually obligated to collect co-payments, co-insurance, and deductibles, as outlined by your insurance carrier.

INITIALS: _____

Please be aware that out-of-network insurance carriers often prohibit assignment of benefits and may try to limit their financial liability with arbitrary limits, exclusions, or reductions such as reasonable and customary or usual and prevailing reductions. Our fees are well within such ranges and although we will assist in the filing of an appeal if these limitations are imposed, you as the guarantor are responsible for all out-of-network fees. If we are not contracted with your carrier we will not negotiate reduced fees with your carrier.

Surgery Deposits

Any refunds due from deposits collected for surgery and/or Co-payments will be processed within **60** days of the insurance company's payment and explanation of benefits. If you have future appointments or surgeries scheduled your refund will be held till all procedures have been processed for payment by your insurance company.

Miscellaneous Forms, Additional Information, and Authorizations

We will provide all necessary information to have your benefits released. There will be an administrative fee of $30.00 for any FMLA paperwork, or work forms. In addition, FMLA paperwork will need at least 1 week to be completed and will not be filled out until **AFTER** surgery.

Missed Appointments

We require notice of cancellations 24 hours in advance. This allows us to offer the appointment to another patient. If you fail to keep your appointments without notifying us in advance: a missed appointment fee will apply. These fees are typically $30.00 but not to exceed half of the cost of your scheduled appointment. Repeated missed appointments without notification may cause you to be discharged from the practice so that we can provide care to other patients.

Medical Records Fee

Patients are entitled under federal law to have access to their protected health information and we follow all rules, guidelines and exceptions to ensure compliance to patient rights. However, providers also have the right to compensation for records and our fees are reasonable cost-based fee for copies including the copying, supplies, labor, and postage of the files, and or summaries. We charge the amount of $1.00 per page for medical records.

We realize that temporary financial problems may affect timely payment of your account. If this should occur, please contact us for assistance in the management of your account. Our goal is to provide quality care and service. Please let us know immediately if you require any assistance or clarification from anyone within our business.

Timeliness of Appointments

We try to see everyone in a timely manner but if we are taking too long, please let our receptionist know so we can better serve your needs and reschedule you if necessary.

I have read and understand the above financial policy. I agree to assign insurance benefits to whenever applicable. I also agree, in addition to the amount owed, I also will be responsible for the fee charged the collection agency for costs of collections if such action become necessary.

Signature of Insured or Authorized Representative: _____

Printed name of Insured or Authorized Representative: _____

Date Signed: _____

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Notice of Privacy Practices for Protected Health Information (HIPAA)

"This Notice Describes How Medical Information About You May Be Used And Disclosed And How You May Get Access To This Information". Please Review It Carefully!

We Safeguard Information about Your Health and Person:
We collect information from you and store it in a medical record as well as on a computer. Charts are stored in a secure area and available only to designated staff and only for designated reasons. Housekeeping, maintenance and other non-office personnel have no access to the chart area. Service technicians may have access to the computer, but only for service of computer operations.

Typical Uses and Disclosures of Medical Information:
We collect medical information from you. Within our office, we restrict the disclosure of this information to doctors, nurses, technicians and insurance and billing personnel. We may use your medical information for treatment and care, payment to insurers and for healthcare operations. Outside our office, we restrict the disclosure to those people, entities and agencies for whom you authorize disclosure such as other healthcare providers (doctors, nurses, extended care facilities), insurance companies, billing agencies, hospitals and surgery sites, or those agencies and entities for whom legal and administrative requirements demand disclosure such as:

- When required by law
- Public health activities (deaths, child abuse, neglect, domestic violence, problems with products, reactions to medications, product recalls, disease/infection exposure, disease/injury/disability control/prevention)
- Health oversight activities (audits, investigations, inspections)
- Judicial and administrative proceedings (court order)
- Appropriate law enforcement requests (to identify or locate a suspect, fugitive, material witness, or missing person)
- Deceased person information to coroners, medical examiners, funeral directors.
- Organ and tissue donation
- Research, provided authorization is IRB-approved or privacy board-approved
- Emergencies or to avert serious threat to health or safety
- Specialized government functions (military, inmates)

- Worker's compensation
- Disaster Relief

We will not use or disclose your medical information for any purpose not listed without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

Patient Privacy Rights:

You Have The Right To:

- Inspect and copy medical information from your chart. You may submit a written request to our office and pay the copy fee and receive a copy of your record. We must respond within 30 days. You may also get an electronic copy if we have one available.
- Amend medical information in your chart. You may identify inaccurate or incomplete information in your chart. You can do this with a written request to amend your chart directed to our office. We must respond within 60 days.
- Receive an accounting of any disclosures made from your record over the last six years, starting April 14, 2003. You can get this with a written request directed to our office. We must respond within 60 days.
- Request restrictions as the amount of medical information we disclose. This is limited as noted above, and your request may not super cede the typical disclosures noted above. You may revoke or restrict the consent.
- Restrict certain disclosures of PHI to a health plan when you pay out of pocket in full for the healthcare item or service.
- Request confidential communications. All communications in our office are confidential. You may specifically-request that all communications be confidential with a written request directed to our office.
- Not to have your protected health information sold for marketing purposes.
- Opt out of receiving fund-raising communications.
- Be notified following a breach of your unsecured protected health information.
- Receive a copy of this notice by printing it or with a written request directed to this office, and a copy of this notice will be given with all new patient packets.

We May Contact You for Appointment Reminders, and we may provide you with information about health-related or product benefits and services.

Each patient is given a copy of the Privacy Notice and an opportunity to review and understand it.

Our Responsibilities under HIPAA:

We are required by Law to maintain the privacy of your personal health information, and to provide you notice of our legal duties and privacy practices and adhere to this notice.

We reserve the right to make changes to this notice. We will post a notice that the notice has been changed and the effective date of the change, copies will be made available.

You can submit a complaint about our privacy policy or its execution either verbally or in writing to our <u>PRIVACY OFFICER</u> at our office.

If you get no resolution to your complaint, you can send a written statement to this office or the Secretary of Health and Human Services.

Effective Date of Notice: **July 2011**
Amended Dates: **January 2017**