PLEASE RETURN THE COMPLETED FORMS TO:

MAIL: **Colo-Rectal Associates**
2566 Haymaker Road Suite 206
Monroeville, PA 15146

E-MAIL: **drjamesbaran@gmail.com**

Instructions to Email Forms:

1) File > Save As > Save to Your Desktop as New Patient Form
2) Login to your Email
3) Compose New Email
4) Attach File (click the paperclip icon) > Select completed New Patient Form document
5) To: drjamesbaran@gmail.com
6) Subject: New Patient Forms
7) Send!

FAX: **412-856-5471**

Call 412-373-8040 with any questions

Name:_____ DOB:

_____

Spouse's Name:_____

Address: Street:_____

City:_____ State:_____ Zip Code:_____

Phone Number: Home:_____

Work:_____

Cell:_____

E-Mail Address:_____

Social Security Number:_____

Referring Doctor:_____

Primary Doctor:_____

EMERGENCY CONTACT: Name:_____

Relationship:_____

Phone Number:_____

REASON FOR TODAY'S VISIT:_____

Do you require antibiotics prior to an exam or procedure? Yes:☐ No:☐

Reason: Heart Valve:☐ Joint Replacement (in last 6 months):☐

Other:_____

Are you currently on a blood thinner other than aspirin / NSAID? Yes:☐ No:☐

Name:_____ Reason:_____

Pharmacy: Name:_____ Location:_____

Phone Number:_____

PERSONAL HISTORY

Name:_____ **Date of Birth:**_____ **Age:**_____

Allergies to any medications: ☐ Yes ☐ No
If yes, please specify medication and describe reaction:_____
_____

Medications you are currently taking:_____
_____
_____

Medical history – check if you are currently being treated or have been treated for any of the following illnesses:

☐ heart problems	☐ high blood pressure	☐ diabetes
☐ cancer	☐ arthritis	☐ lung problems
☐ liver problems	☐ kidney problems	☐ stroke
☐ seizure	☐ ulcer	☐ reflux/hiatal hernia
☐ prostate	☐ uterus/ovary	☐ OTHER _____

Operations in the past:

☐ tonsils	☐ appendix	☐ gall bladder
☐ stomach	☐ colon	☐ hemorrhoid
☐ hernia	☐ chest	☐ breast
☐ prostate	☐ hysterectomy	☐ ovary
☐ tubal ligation	☐ c-section	☐ bone/joint

☐ OTHER_____

Social history:
Marital status ☐ Single ☐ Married ☐ Widowed ☐ Divorced
With whom do you live?
Occupation:
Do you smoke? ☐ Yes ☐ No How many packs per day?_____ How many years?____
Do you drink alcohol? ☐ Yes ☐ No How much?_____
Do you use any drugs? ☐ Yes ☐ No

Family history:
Check if any close family member (parents, brothers, sisters, children) have or had:

☐ colon cancer	☐ other cancer	☐ heart problems
☐ high blood pressure	☐ diabetes	☐ OTHER_____

Did you have a colonoscopy (scope) or barium enema x-ray in the last 5 – 10 years?
☐ Yes ☐ No

Name: **DOB:**

Review of Systems:

Please check any symptoms you are currently experiencing:

Constitutional:
- ☐ lack of energy
- ☐ trouble sleeping
- ☐ loss of appetite
- ☐ weight loss
- ☐ weight gain
- ☐ fevers

HEENT:
- ☐ double or blurred vision
- ☐ buzzing or ringing in ears
- ☐ hay fever
- ☐ sinus problems

Cardiovascular:
- ☐ chest pain
- ☐ palpitations
- ☐ high blood pressure
- ☐ swollen legs

Respiratory:
- ☐ wheezing
- ☐ coughing
- ☐ coughing blood
- ☐ shortness of breath

Digestive:
- ☐ indigestion
- ☐ change in bowel habits
- ☐ bloody or tarry stools
- ☐ diarrhea
- ☐ constipation/straining

Urinary:
- ☐ urinary frequency
- ☐ urinary infections
- ☐ difficulty urinating

Musculoskeletal:
- ☐ joint pains/swelling/redness
- ☐ muscle aches/tenderness

Dermatological:
- ☐ rash/itching/other skin problems

Neurological:
- ☐ numbness/tingling
- ☐ loss of balance
- ☐ seizures
- ☐ loss of memory
- ☐ headaches

Psychiatric:
- ☐ nervousness
- ☐ depression

Endocrine:
- ☐ thyroid disorder
- ☐ excess thirst
- ☐ excess hunger
- ☐ excess urination

Hematologic:
- ☐ bleeding
- ☐ easy bruising
- ☐ anemia

I certify that all information on these pages are, to the best of my knowledge, true and correct.

Patient Signature:_____ **Date:**_____

Physician Signature:_____ **Date:**_____

Bowel Symptom Questionnaire

Name: Date:

Which symptoms best describe you? Select all that apply.

- ☐ ◊ Accidental loss or leakage of stool-sometimes unable to make it to the bathroom in time
- ☐ ◊ Bowel accidents while unaware– no warning and or asleep
- ☐ ◊ Frequent, loose, watery stools
- ☐ ◊ Sudden or strong urge to go the bathroom
- ☐ ◊ Bowel accidents when passing gas
- ☐ ◊ No bowel problems (if checked please discontinue questionnaire)

How long have you had these symptoms?

Approximately how many bowel accidents do you have per week?

Have you tried medications to help your symptoms? ☐ **YES** ☐ **NO**

Which medications have you tried?

On a scale of 1-10, with 1 being no symptom relief and 10 being complete symptom relief, how much symptom relief have these medications provided for you?

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

Behavior modifications tried? (lifestyle changes, fiber, diet, physical therapy)

On a scale of 1-10, with 1 being no frustration at all and 10 being extremely frustrated, what is your level of frustration with your bowel control symptoms?

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

Are you interested in learning more about other treatment options that may decrease your bowel accidents by 50% or more?

☐ **YES** ☐ **NO**

INSURANCE INFORMATION:

IF YOU ARE NOT THE POLICY HOLDER OF YOUR INSURANCE PLEASE INCLUDE ALL INFORMATION SO THAT WE CAN SUBMIT YOUR CLAIM IN THE MOST EFFICIENT MANNER POSSIBLE. THANK YOU.

POLICY HOLDERS NAME_____

DOB_____**EMPLOYER**_____

RELATIONSHIP TO PATIENT_____

AUTHORIZATION TO BILL FOR SERVICES:

ALL INSURANCE CARRIERS

I give Colo-Rectal Associates permission to release any information to the insurance company to help in payment of my bill. I authorize payment directly to Colo-Rectal Associates for any surgical, office, and/or major medical benefits. I understand I am financially responsible for all charges not covered by this authorization and for any balance thereof.

Signature_____Date_____

FOR MEDICARE AND MEDICARE HMO PATIENTS ONLY

I request the payment of authorized benefits be made either to me or on my behalf, to Colo-Rectal Associates for any service furnished me by that group of physicians. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits to related services.

I, the patient names above, request that payment of authorized Medigap benefits be made either to me or on my behalf to Colo-Rectal Associates for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to Colo-Rectal Associates or the insurance company any information needed to determine these benefits payable for related services.

Signature_____Date_____

COLO-RECTAL ASSOCIATES

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE READ IT CAREFULLY

USES AND DISCLOSURES

Treatment. Your health information may be used by staff members or disclosed to other healthcare professionals for the purpose of evaluating your health, diagnosing medical conditions and providing treatment. For example, results of laboratory tests and procedures will be available in your medical health record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plans. For example, your health plan may request and receive information of dates of service, the services provided and the medical condition being treated.

Healthcare Operations. Your health information may be used as necessary to support day-to-day activities and management of Colo-Rectal Associates. For example, information on the services you received may be used to support budgeting and financial reporting and activities to evaluate and promote quality.

Law Enforcement. Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law enforcement investigations and to comply with government mandated reporting.

Public Health Reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other Uses and Disclosures Require Your Authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your authorization, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

ADDITIONAL USES OF INFORMATION

Appointment Reminders. Your health information will be used by our staff to send you appointment reminders.

Individual Rights. You have certain rights under the federal standards. These include:

- The right to request restriction of the use and disclosure of your protected health information

- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

COLO-RECTAL ASSOCIATES DUTIES

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We are also required by law to abide by the privacy policies and practices that are outlined in this notice.

RIGHT TO REVISE THESE PRIVACY PRACTICES

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our privacy policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next visit. The revised policies and practices will be applied to all protected health information we maintain.

REQUESTS TO INSPECT PROTECTED HEALTH INFORMATION

As permitted by federal regulation, we require that requests to inspect, copy or amend protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the receptionist or Privacy Officer.

COMPLAINTS OR FURTHER INFORMATION

If you would like to submit a comment or complaint, or you would like more information concerning your privacy policies, you can do so by sending a letter outlining your questions or concerns to

Colo-Rectal Associates
2566 Haymaker Road, Suite 206
Monroeville, PA 15146
412-373-8040

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

EFFECTIVE DATE

This notice is effective on or after 04/14/2015.

COLO-RECTAL ASSOCIATES
CONSENT TO USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION

Use and Disclosure of Your Protected Health Information
Your protected health information will be used by Colo-Rectal Associates or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Notice of Privacy Practices
You should review the Notice of Privacy Practices for a more complete description of how your protected health information may by used or disclosed. You may review the notice prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of Your Information
You may request a restriction on the use or disclosure of your protected health information. Colo-Rectal Associates may or may not agree to restrict the use or disclosure of your protected health information. If Colo-Rectal Associates agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected health information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent
You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices
Colo-Rectal Associates reserves the right to modify the privacy practices outlined in this notice.

Signature
I have reviewed this consent form and give my permission to Colo-Rectal Associates to use and disclose my health information in accordance with it

_____
Name of Patient (please print)

_____ Date_____
Signature of patient or Patient's Representative

_____
Relationship of Patient Representative to Patient

Please List the Persons to Whom Information May Be Disclosed

_____
Name of person or organization

_____
Name of person or organization

_____
Name of person or organization