ADVANCED GASTROENTEROLOGY OF NAPLES, LLC

Dr. Shardul Nanavati, M.D.
4760 Tamiami Trail North Suite #27
Naples, FL 34103
Phone Number: 239-593-9599 Fax# 239-593-4099

NEW PATIENT INFORMATION QUESTIONNAIRE

Date of Appointment ____ Reason for Visit ____

Please enter your demographic information in the spaces below.

First Name ____ Last Name ____ MI ____

SSN ____ Date of Birth ____ Gender: ☐ Male ☐ Female

Occupation ____ Referring Provider ____

Primary Care Provider ____

Address Line 1 ____ Address Line 2 ____

City ____ State ____ Zip Code ____ Country ____

Preferred Phone ____ Home Phone ____ Work Phone ____

Cell Phone ____ E-mail address ____

Emergency Contact 1 ____ Phone Number ____

Emergency Contact 2 ____ Phone Number ____

Pharmacy Name ____ Pharmacy Phone Number ____

Pharmacy Address ____

Please enter your insurance information in the spaces below

Primary Insurance ____

Policy Number ____

Group Number ____

☐ Self ☐ Other

Secondary Insurance ____

Policy Number ____

Group Number ____

☐ Self ☐ Other

Insured Information, if not self.

Relation to patient ____

First Name ____

Last Name ____

SSN ____

Date of Birth ____

Gender ☐ Male ☐ Female

Address ____

City, State, Zip ____

Phone Number ____

History and Intake Form

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial fibrillation
Bone Marrow Transplant
Benign Prostatic Hyperplasia
Breast Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
Hearing Loss
High Blood pressure
HIV/AIDS
High Cholesterol
Thyroid Problems
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke

NONE

Other ____

Past Surgical History: (please circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Colostomy
Gallbladder Removed
Coronary Artery Bypass
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement
Joint Replacement within last 2 years
Kidney Biopsy (Nephrectomy)
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP (Prostate Removal)
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
Colonoscopy
Endoscopy – EGD

NONE

Other ____

Gastroenterology Disease History: (please circle all that apply)

Achalsia
Alcoholic Hepatitis
Anal Fissures
Ascites
Autoimmune Hepatitis
Barrett's Esophagus
Celiac Sprue
Cholecystitis
Choledocholithiasis
Dyspepsia
Esophageal Cancer
Esophageal Varicies
Gastric Cancer
Gastroparesis
GERD
Gilbert's Syndrome
Gluten Intolerance
Hemorrhoids
Hepatic Encephalopathy
Hepatitis B
Choletithiasis
Chronic Constipation
Cirrhosis
Colon Cancer
Crohn's Disease
C Diff Colitis
Diverticulitis
Diverticulosis
Hepatitis C
Hiatal Hernia
H Pylori Infection
Iron Deficiency Anemia
Irritable Bowel Syndrome
Lactose Intolerance
Microscopic Colitis
NASH
Pancreatitis
Peptic Ulcer Disease
Portal Hypertension
Primary Billiary Cirrhosis
Spontaneous Bacterial
Peritonitis
Small Bowel Obstruction
Ulcerative Colitis
Upper GI Bleeding

NONE

Other: ____

Medications: (Please enter all current medications, including name, dosage, frequency and route - how you take it: orally, injection, nasally, etc.)

____

____

____

Allergies: (Please enter all allergies and Reactions)

____

____

____

Social History: (Please circle all that apply)

Cigarette Smoking:

Current every day smoker
Current some day smoker (tobacco)
Current some day smoker (cigarette)
Former Smoker
Never smoker
Cigar smoker
Light tobacco smoker
Heavy tobacco smoker

Alcohol Use:

None
Less than 1 drink per day
1-2 drinks per day
3 or more drinks per day

Other____

Family History (Only first-degree relatives Mother, Father, Daughter, Son, Sister or Brother)

Disease	Relative	Disease	Relative
Colon Cancer		Gallbladder Disease	
Esophageal Cancer		Liver Disease	
Stomach Cancer		Malignant Neoplasm (Billary tract)	
Celiac Disease		Malignant Neoplasm (Pancreas)	
Crohn's Disease		Colon Polyps	
Diverticulitis		Ulcerative Colitis	

Preferred Language: ___________________________

Race:______________________ **Ethnic Group**:_________________________

Preferred pharmacy Name: _________________________ **Street name**:______________________________

Phone#: ____________________________ **City or Zip code**: _____________________

Review of Systems: Are you currently experiencing any of the following?
(Please check yes or no for the following)

Symptom	Yes	No
Problems with bleeding		
Problems with healing		
Problems with scarring		
Rash		
Immunosuppression		
Hay fever		
Chest pain		
Fever or chills		
Night sweats		
Unintentional weight loss		
Thyroid problems		
Sore throat		
Blurry vision		
Abdominal pain		
Bloody stool		
Bloody urine		
Joint aches		
Muscle weakness		
Neck stiffness		
Headaches		
Seizures		
Cough		
Shortness of breath		
Wheezing		
Anxiety		
Depression		
Allergy to adhesive		
Allergy to lidocaine		
Allergy to topical antibiotic ointments		
Artificial heart valve		
Artificial joints in the last two years		
Blood thinners		
Defibrillator		
MRSA		
Pacemaker		
Pregnancy or planning pregnancy		

Other Symptoms: ____

Advanced Gastroenterology of Naples
4760 Tamiami Trail N Ste 27
Naples, FL 34103
239-593-9599

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

NOTICE OF PRIVACY PRACTICES PURSUANT TO 45 C.F.R. § 164.520

Our Duties

We are required by law to maintain the privacy of your Protected Health Information ("PHI"). PHI consists of individually identifiable health information, which may include demographic information we collect from you or create or receive by another health care provider, a health plan, your employer, or a health care clearinghouse, and that relates to: (1) your past, present or future physical or mental health or condition; (2) the provision of health care to you; or (3) the past, present or future payment for the provision of health care to you.

We must provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of our Notice of Privacy Practices currently in effect. However, we reserve the right to change our privacy practices in regard to PHI and make new privacy policies effective for all PHI that we maintain. We will post a copy of our current Notice of Privacy Practices in the waiting room, and keep a copy of the revised Notice at the registration desk, and provide you with a copy upon your request, and if we maintain a website, we will post our Notice of Privacy Practices on our website.

Examples of Uses and Disclosures of Your PHI relating to Treatment, Payment & Operations

HIPAA privacy regulations give us the right to use and disclose your PHI without your consent to carry out (i) treatment, (ii) payment, and (iii) health care operations. Here are some examples of how we intend to use of your PHI in regard to your treatment, payment, and health care operations.

Treatment. In connection with treatment, we will, for example, use and disclose your PHI to provide, coordinate, or manage your health care and any related services. We will disclose your PHI to other providers who may be treating you. Additionally, we may disclose your PHI to another provider who has been requested to be involved in your care.

Payment. We will use your PHI to obtain payment for our services, including sending claims to your insurer or to a federal program, such as Medicare, that pays for your treatment and sending you a bill for any amounts due which your insurer does not pay. We may also employ Business Associates, such as a billing company or collection agency to help us bill and collect. The PHI will include items such as description of your condition(s), our treatment, your diagnosis, supplies and drugs we used, etc.

Health Care Operations. We will use your PHI to support our business activities, such as allowing our auditors, consultants, or attorneys access to your PHI to audit our claims to determine if we billed you accurately for the services we provided to you, or to evaluate our staff to see if they properly cared for you, or to send information about you to third party Business Associates so they may perform some of our business operations.

Description of Other Required or Permitted Uses and Disclosures of Your PHI

Appointment Reminders. We will call you to remind you of an appointment. We may call your residence, office, or any other number we have on file. We will leave a message if you are not in, and we will state the name of our clinic, the date and time of the appointment, and the address at which the appointment is to be kept. We may also mail you a notice of your appointment to any address we have on file.

As Required by Law. We will use and disclose your PHI when required to by federal, state, or local law. For example, we may receive a subpoena for which we are required by law to provide copies of your medical file.

To Avert a Serious Threat to Public Health or Safety. We will use and disclose your PHI to public health authorities permitted to collect or receive the information for the purpose of controlling disease, injury, or disability. If directed by that health authority, we will also disclose your health information to a foreign government agency that is collaborating with the public health authority.

Workers Compensation. We will use and disclose your PHI for workers compensation or similar programs that provide benefits for work-related injuries or illness.

Inmates. If you are an inmate, we will use and disclose your PHI to a correctional institution or law enforcement official only if you are an inmate of that correctional institution or under the custody of the law enforcement official. This information would be necessary for the institution to provide you with health care; to protect the health and safety of others; or for the safety and security of the correctional institution.

Other Services and/or Fundraising. We may use your PHI to contact you with information about treatment alternatives or other health-related benefits and services that, in our opinion, may be of interest to you. We may use your PHI to contact you in an effort to raise funds for our operations, however, you have the right to opt out of receiving any fundraising communications by sending a letter to our Privacy Officer in writing at the address at which you are treated.

Uses and Disclosures to which You have an Opportunity to Object

Others Involved in Your Care. We may provide relevant portions of your PHI to a family member, a relative, a close friend, or any other person you identify as being involved in your medical care or

payment for care. If you bring someone with you into a treatment room, you are hereby notified that you will have identified that person to us as being involved in your care or payment for your care, by voluntarily bringing them in the room. If you do not object to us discussing your PHI in front of them, we may discuss your PHI in their presence because you did not object. In an emergency or when you are not capable of agreeing or objecting to these disclosures, we will disclose PHI as we determine is in your best interest, but will tell you about it after the emergency, and give you the opportunity to object to future disclosures to family and friends.

Uses and Disclosures that Require Your Signed Authorization

There are certain uses and disclosures of your PHI that require your written authorization. For example, most uses and disclosures of psychotherapy notes (where appropriate), uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI require your signed authorization. Also, any use or disclosure of your PHI not described in this Notice requires your signed authorization.

Your Right to Revoke Your Authorization

If you sign an authorization allowing us to use or disclose your PHI outside of the uses and disclosures made in this Notice, you may revoke that authorization by advising us in writing with a letter addressed to Privacy Officer, at the address where we treat you. Your revocation will become effective as soon as we are reasonably able to enter it into our records, which is typically within 5 business days after we receive the letter. Your revocation will not affect our prior reliance on your authorization prior to the effective date of revocation.

Your Right to Restrict Certain PHI to a Health Plan

You have the right to require us to restrict any disclosure of your PHI to a health plan regarding an item or service for which you (or someone on your behalf - other than a health plan) paid out-of-pocket to us the entire amount due for the health care item or service which we provided and billed to you. You must make such a request in writing to us, with a letter addressed to Privacy Officer at the address where you receive your treatment. If you make such a request, we are required to honor it.

Notification in Case of Breach of Unsecured PHI

In the event of an unauthorized or improper use or disclosure of your PHI (i.e., a "breach"), you have the right to receive, and we will notify you of the circumstances surrounding, the breach, what we have done to investigate and mitigate it, and how to best protect yourself in our opinion.

Patient Rights Related to PHI

In addition to your other rights provided herein, you have the right to:

Request an Amendment. You have the right to request that we amend your medical information if you feel that it is incomplete or inaccurate. You must make this request in writing to our Privacy Officer, stating what information is incomplete or inaccurate and the reasoning that supports your request. We are permitted to deny your request if it is not in writing or does not include a reason that we believe supports the request. We may also deny your request if the information was not created by us, or the person who created it is no longer available to make the amendment.

Request Restrictions. You have the right to request a restriction of how we use or disclose your medical information for treatment, payment, or health care operations. For example, you could request that we not disclose information about a prior treatment to a family member or friend who may be involved in your care or payment for care. Your request must be made in writing to the Privacy Officer addressed to the address at which you receive care. We are not required to agree to your request. If we do agree, we will comply with your request except for emergency treatment.

Inspect and Copy. You have the right to inspect and copy the PHI we maintain about you in our designated record set for as long as we maintain that information. This designated record set includes your medical and billing records, as well as any other records we use for making decisions about you. Any psychotherapy notes that may have been included in records we received about you are not available for your inspection or copying, by law. We may charge you a fee for the costs of copying, mailing, or other supplies used in fulfilling your request. If you wish to inspect or copy your medical information, you must submit your request in writing to our Privacy Officer at address at which you receive treatment. We will have 30 days to respond to your request for information that we maintain at our facility. If the information is stored off-site, we are allowed up to 60 days to respond but must inform you of this delay. HITECH expands this right, giving individuals the right to access their own e-health record in an electronic format if we maintain your records in an electronic format, and to direct us to send the e-health records directly to a third party. We may only charge for labor costs under electronic transfers of e-health records.

An Accounting of Disclosures. You have the right to request a list of the disclosures of your health information we have made that were not for treatment, payment, or health care operations. Your request must be in writing and must state the time period for the requested information. You may not request information for any dates prior to April 14, 2003, nor for a period of time greater than six years (our legal obligation to retain information). Your first request for a list of disclosures within a 12-month period will be free. If you request an additional list within 12-months of the first request, we may charge you a fee for the costs of providing the subsequent list. We will notify you of such costs and afford you the opportunity to withdraw your request before any costs are incurred.

Request Confidential Communications. You have the right to request how we communicate with you to preserve your privacy. For example, you may request that we call you only at your work number, or by mail at a special address or postal box. Your request must be made in writing and must specify

how or where we are to contact you. We will accommodate all reasonable requests; however, we will not accommodate a request that we perceive is an attempt to avoid receiving notice of a bill for the payment of our services.

File a Complaint. If you believe we have violated your medical information privacy rights, you have the right to file a complaint with us or directly to the Secretary of the United States Department of Health and Human Services: U.S. Department of Health & Human Services, 200 Independence Avenue, S.W. Washington, D.C. 20201, Phone: (202) 619-0257, Toll Free: (877) 696-6775. To file a complaint with us, you must make it in writing within 180 days of the suspected violation. Provide as much detail as you can about the suspected violation and send it to our Privacy Officer at the address at which you were treated. No patient will be retaliated against for making a complaint.

A Paper Copy of This Notice. You have the right to receive a paper copy of this notice upon request. You may obtain a copy by asking for it.

Contact Person

You may contact our Privacy Officer, Gina Vaughn, RN at the following phone number for any questions:
Phone number: 239-260-7324

Effective Date

The effective date of this revised Notice of Privacy Practices is March 26, 2013.

Advanced Gastroenterology of Naples
4760 Tamiami Trail N Ste 27
Naples, FL 34103
239-593-9599

Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I have received from Advanced Gastroenterology of Naples a copy of a separate document, entitled, "Notice of Privacy Practices" which sets forth Advanced Gastroenterology of Naples privacy practices and my rights regarding privacy of my protected health information.

_________________________________ _________________________________

PATIENT SIGNATURE **DATE**
Or Personal Representative

LIFETIME AUTHORIZATION
INSURANCE ASSIGNMENTS AND AUTHORIZATION
TO RELEASE INFORMATION AND
FINANCIAL POLICY

I. **RELEASE OF INFORMATION** – I, the below named patient, do hereby authorize any physician examining and/or treating me to release to any third party payer (such as an insurance company or government agency, example: Blue Cross Blue Shield of Florida or Medicare) any medical, psychiatric condition, alcohol, or drug related condition and records concerning diagnosis and treatment when requested by such third party for its use in connection with adjudicating a claim for such treatment and/or diagnosis.

II. **PHYSICIAN INSURANCE ASSIGNMENT** – I, the below named subscriber, hereby authorize payment directly to any physician examining or treating me of any group and/or individual surgical and/or medical benefits herein specified and otherwise payable to me for their services.

III. **MEDICARE/MEDICAID** – Patient's authorization to release information and payment request. I certify that the information given by me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security Administration/Division of Family Services or its intermediaries or carriers any information needed for this or a related Medicare/Medicaid claim. I hereby certify all insurance payments pertaining to treatment shall be assigned to the physician treating me.

IV. **GUARANTEE OF PAYMENT** – I, the below named patient/guarantor, does hereby guarantee payment of all charges incurred for the account of the patient named below. I further agree to waive demand and notice of nonpayment and protest and in case suit shall be brought for the collection hereof, for the same collected upon demand of any attorney, I agree to pay all cost of collection, including reasonable attorney's fee.

V. **I PERMIT A COPY OF THESE AUTHORIZATIONS AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE.** This assignment will remain in effect until revoked by me in writing.

CANCELLED APPOINTMENTS - Patients who do not cancel appointments may be discharged from the practice after the third no show. There will be a $100.00 cancellation fee for all procedures missed or cancelled without 48 hours prior notice. There will be a $50.00 no show fee for all office visits, unless a 24 hour notice was given.

PAYMENT FOR SERVICE IS DUE AT THE TIME SERVICES ARE RENDERED – We accept cash, MasterCard, Visa, Discover, American Express. We do not accept checks. If a check is sent to our office and it is returned by the bank there will be a service charge of $35.00 or 5% of the face value of the check. There is a $50.00 fee for any form to be filled out by the physician.

ALL CHARGES ARE YOUR RESPONSIBILITY FROM THE DATE SERVICES ARE RENDERED

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. Please be aware if after 3 statements and one phone call to the number on file we have yet to receive payment in full for a past due balance it is possible your account could be sent to a collections agency. We do offer a financial hardship please ask for an application if you believe you may qualify. I understand it is my responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by my insurance or third party payer within a reasonable period of time not to exceed 60 days.

ASSIGNMENT AND RELEASE

I, the undersigned, assign directly to Pain Management Center of Naples all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of his signature on all my insurance submissions.

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made to either me or on my behalf to Pain Management Center of Naples for any services furnished to me by that physician. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the CMS-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier

______________________________	____________________
Beneficiary Signature	Date
______________________________	____________________
Subscriber Signature (if different from patient)	Date