COLORECTAL SURGICAL ASSOCIATES, PC
kansas city's leading colon & rectal specialists since 1991

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1. Please print, complete and sign these forms.
2. Please bring completed paperwork with you to your appointment.
3. Bring your insurance card(s) and a photo I.D.
4. If you have FMLA/STD/AFLAC that needs to be completed, please give to the front desk. There is $30 fee to complete each set of forms. The completed paperwork will need to be paid at the time you request to have the form completed.
5. Please arrive 15 minutes before your scheduled appointment time for us to be able to process your paperwork and for you to fill out additional paperwork before your appointment time.
6. If you have had a colonoscopy please bring copy of most current report.
7. If you are seeing one of our physicians for a colon/rectal mass or colon/rectal cancer please make sure to bring your colonoscopy report, pathology report, and CT scan report.
8. If a rectal exam is needed as part of your exam on the day of your appointment, a separate charge will occur for that exam and per AMA guidelines, the charge is considered a surgical procedure and will be processed separate from your office visit.

Colorectal Surgical Associates

Patient Name: _____ Title_____ Previous Name(s):_____
Home Address: Street: _____
City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____
Email:_____
Referring Physician: _____ Primary care physician(PCP): _____
Cardiologist:_____ Gastroenterologist:_____
Birth Date: _____ Sex: Male Female Transgender
Social Sec #: _____ -_____-_____ **Do you have a Living Will:** Y N
Please Circle: Race: American Indian /Alaska Native Asian Native Hawaiian/Other Pacific Islander Black African American White Declined to Answer
Ethnicity: Hispanic or Latino Not Hispanic or Latino Declined to Answer
Spoken Language: _____ **Translator Requested/Needed**: Yes No
Marital Status: Married Single Divorced Widowed Legally Separated Partner
Employment Status: Full-Time Part-Time Not Employed Self-Employed Retired Active Military
Employer: _____ Occupation:_____
Student Status: F - Full-Time Student P - Part-Time Student N-Not Applicable
How Did You Hear About Us(circle all that apply): Referral Health Insur/Payer Newspaper/Magazine Clinic Website Online Engine Search Facebook Twitter You-Tube Phone Book Mailer Billboard Clinic Signage Smartphone App ER Hospital Admit Other
Pharmacy of Preference for Prescription Pick-Up: _____

Pharmacy Address:_____ Pharmacy Phone Number:_____

Emergency Contact: _____Relationship: _____
Home Phone: _____ Alternative Phone: _____
FOR YOUR PRIVACY PLEASE NOTE THAT WE MAY CONTACT THIS PERSON IF WE CAN NOT CONTACT YOU

Responsible Party (if other than patient/ minor): _____
Phone #: _____ Address (if different then patients): _____

All Patient Must Provide Insurance Card(s) to Front Desk Upon Check In and this section must be filled out completely

Primary Insurance Name: _____
Policy/ID #: _____ Group #: _____
Subscriber name: _____ Phone# _____DOB: _____
SS#: _____ Gender: F M
Secondary Insurance Name: _____
Subscriber name: _____ Phone# _____DOB: _____
SS#: _____ Gender: F M

MESSAGES: Please check all that apply

- ☐ On answering machine or voicemail at home
- ☐ On cell phone
- ☐ On answering machine or voicemail at work
- ☐ I do not consent to messages being left at home, work or with any other person

I agree that the information supplied on this form is accurate and up to date to the best of my knowledge.

Patient (or Responsible Party) Signature _____ Date_____

Colorectal Surgical Associates

General Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

X_____ _____

Signature of Patient or Personal Representative **Date**

Printed Name of Patient or Personal Representative **Relationship to Patient**

Printed Name of Witness **Employee Job Title**

_____ _____ **Signature of Witness**

Date

Notice of Privacy Practice/clinics

_____ (**Patient/Representative initials)** I acknowledge that I have received the Notice of Privacy Practice, which describes the ways in which the practice/clinic may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the Notice of Privacy Practice.

Disclosures to Friends and/or Family Members

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM? I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1:			
2:			
3:			

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

Communications about My Healthcare

I agree the Provider or an agent of the Provider or an independent physician's office may contact me for the purposes of scheduling necessary follow-up visits recommended by the treating physician.

Consent for Photographing or Other Recording for Security and/or Health Care Operations

I consent to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice's/clinic's health care operations purposes (e.g., quality improvement activities). I understand that the practice/clinic retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside the facility without a specific written authorization from me or my legal representative unless otherwise permitted or required by law.

Consent to Email, Cellular Telephone, or Text Usage for Appointment Reminders and Other Healthcare Communications

If at any time I provide an email address or cellphone number at which I may be contacted, I consent to receiving unsecure instructions and other healthcare communications at the email or text address I have provided or you or your EBO Servicer have obtained, at any text number forwarded, or transferred from that number. These instructions may include, but not be limited to: post-procedure instructions, follow-up instructions, educational information, and prescription information. Other healthcare communications may include, but are not limited to, communications to family or designated representatives regarding my treatment or condition, or reminder messages to me regarding appointments for medical care.
Note: You may opt out of these communications at any time. The practice/clinic does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Note: This location uses an Electronic Health Record that will update all your demographics and consents to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated locations that share an electronic health record in which you have a relationship.

Release of Information.

I hereby permit practice/clinic and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior service(s) at other HCA affiliated providers may be made available to subsequent HCA-affiliated providers to coordinate care. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may

include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.

- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

I certify that I have read and fully understand the above statements from all pages and consent fully and voluntarily to its contents.

Patient/Representative Signature	Relationship to Patient (self, parent, legal guardian/representative, etc)	Date

Practice:OPTIONAL ON FORM- REMOVE THIS Prescription Order Pick up Section **ONLY** if NA to your practice/clinic]
Prescription Order Pick-up. There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

- ***I do want*** ____ (Patient/Representative Initials) to designate the following individual to pick up a prescription order on my behalf:

NAME	Relationship to Patient

- ***I do not want*** ____ (Patient/ Representative Initials) to designate anyone to pick-up my prescription order.

Colorectal Surgical Associates

1. **_____(Patient or Guardian Initials)**

Financial Agreement.

- I acknowledge, that as a courtesy, **Colorectal Surgical Associates** may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand that there is a fee for returned checks.

2. **_____(Patient or Guardian Initials)**

Third Party Collection. I acknowledge that **Colorectal Surgical Associates** may utilize the services of a third party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

3. **_____(Patient or Guardian Initials)**

Assignment of Benefits. I hereby assign to **Colorectal Surgical Associates** any insurance or other third-party benefits available for health care services provided to me. I understand **Colorectal Surgical Associates** has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to **Colorectal Surgical Associates,** I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

4. **_____(Patient or Guardian Initials)**

Consent to Telephone Calls for Financial Communications. I agree that, in order for **Colorectal Surgical Associates**, or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that **Colorectal Surgical Associates** or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or **Colorectal Surgical Associates** or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

5. **_____(Patient or Guardian Initials)**

A photocopy of this consent shall be considered as valid as the original.

Patient/Patient Representative Signature:

X_____Date_____

If you are not the Patient, please identify your Relationship to the Patient.

(Circle or mark relationship(s) from list below):

Spouse Parent Legal Guardian Healthcare Power of Attorney
Guarantor Other:_____

Colorectal Surgical Associates

PATIENTS NAME:_____

Social History:

Caffeine Use O Yes O No

If Yes, Number of cups a Day?_____

Marital Status: O Single O Married

O Divorced O Widow(er) O Partnership

Occupation:_____

Medical History:

High Blood Pressure O Yes O No
Low Blood Pressure O Yes O No
COPD O Yes O No
Heart Disease O Yes O No
Sore and/or Bleeding Gums O Yes O No
Missing Teeth O Yes O No
Dentures/Crowns/Bridges O Yes O No
Dental Fillings O Yes O No
Bright Red Stools O Yes O No
Anal Burning and Itching O Yes O No
Anal Pain O Yes O No
Bleeding on Toilet Tissue O Yes O No
Urge to Defecate O Yes O No
Frequent Stools O Yes O No
Stool Leakage O Yes O No
Black Stools O Yes O No
Laxatives O Yes O No
If Yes, Which One?_____
Pain After Eating O Yes O No
If Yes, Where?_____
Irritable Bowel Syndrome O Yes O No
Ulcerative Colitis O Yes O No
Crohn's Disease O Yes O No
Cancer O Yes O No
If Yes, Type(s):_____
Arthritis (including Rheumatoid) O Yes O No
Lupus O Yes O No
Fibromyalgia O Yes O No
Kidney Disease O Yes O No
Dialysis O Yes O No
Jaundice O Yes O No
Hepatitis O Yes O No
If Yes, Type:_____
Diabetes O Yes O No
If Yes, Type:_____
Anemia O Yes O No
HIV O Yes O No
Pneumonia O Yes O No
Epilepsy O Yes O No
Seizure Disorder O Yes O No
Thyroid Disease O Yes O No

Anesthesia Problems O Yes O No
Birth Defect O Yes O No
Blood Clots O Yes O No
Sleep Apnea O Yes O No
Stomach Ulcers O Yes O No
TB(Tuberculosis) O Yes O No

Surgical History:

Colonoscopy: O Yes O No
If Yes, Yr?_____
Name of Dr:_____
Polyps Found O Yes O No
Normal Results O Yes O No
Laparoscopy O Yes Ono Yr?_____
Colon resection O Yes O No Yr?_____
Pacemaker O Yes O No Yr?_____
Low Anterior Resection O Yes O No Yr_____
Artificial joint(knee, hip, etc) O Yes O No Yr____
Right/Left/Both:_____
Heart Bypass O Yes O No Yr?_____
Thyroid O Yes O No Yr?_____
Prostate O Yes O No Yr?_____
Mastectomy O Yes O No Yr?_____
If Yes, O Laparoscopic O Open
Hysterectomy O Yes O No Yr?_____
If Yes, O abdominal O vaginal O Laparoscopic
Gallbladder O Yes O No Yr?_____
If Yes, O Laparoscopic O Open
Appendectomy O Yes O No Yr?_____
If Yes, O Laparoscopic O Open
Heart Stent(s) O Yes O No Yr?_____
Breast lump O Yes O No Yr?_____
Heart Valve O Yes O No Yr?_____
Bladder/cystocele/rectocele) O Yes O No Yr?___
Hernia O Yes O No Yr?_____
Tonsillectomy O Yes O No Yr?_____
Blood Transfusion O Yes O No Yr?_____
Nissen Fundoplication or Stomach Stapling
Yes O No Yr?_____

O List any other surgeries/hospitalization below:

_____
_____
_____

Women Only Menstrual History:

Last Menstrual Period:_____
Are You Pregnant: O Yes O No
Obstetrics: _____# Pregnancies
_____#Vaginal _____# C-Sections
History or Episiotomy or Vaginal Tearing
O Yes O No

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Pts Name:_____

Review of Systems: PLEASE CIRCLE ALL THAT YOU ARE EXPERIENCING AT THIS TIME

Check Box if you are experiencing none of the below symptoms/conditions today ☐

Weight Change Loss of Appetite Fever Weakness Fatigue Night Sweats

---

Cold Cough Nose Bleeding Hearing Loss Change in Voice Sore Throat Sinus Pain

---

Shortness of Breath Murmurs Palpitations Blue Coloration of Skin

Dizziness Chest Pain Edema

Difficulty Swallowing Abdominal Pain Nausea Vomiting Constipation

Diarrhea Blood in Stool Stool Changes

Joint Pain

Depression Sleep Disturbances Suicidal Ideation ADHD
Anxiety

Rash Moles/Freckles Eczema Hive Keloid Formations Skin Cancer Bruising

---

Excessive Sweating Excessive Thirst Excessive Urination Sleep Disturbance

Cold Intolerance Heat Intolerance

Headaches Seizures Insomnia

Memory Loss Gait Abnormality

Eye Irritation Drainage from Eyes Blurring of Vision

Easy Bleeding Swollen Glands

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FEMALE ONLY—Two Lines Below

Abnormal Vaginal Bleeding **Hot Flashes** **Abnormal Vaginal Discharge**

Urinating Symptoms **Pelvic Pain**

MALE ONLY—Two Lines Below

Hernia **Testicle Changes**

Social History--SMOKING, ALCOHOL AND DRUG QUESTIONAIRE:

(Please Fill in Bubbles)—TO BE COMPLETED BY ALL PATIENTS

Smoking Screening

Are you a:

O current smoker O former smoker Yr Quit:___ O nonsmoker

If "former smoker": How long has it been since you last smoked?

O <1 month O 1-3 months O 3-6 months O 6-12 months O 1-5 years
O 5-10 years O >10 years

If "current smoker": Are you interested in quitting?

O Ready to quit O Thinking of quitting O Not ready to quit

If "current smoker": How many cigarettes a day do you smoke?

O 5 or less O 6-10 O 11-20 O 21-30 O 31 or more

If "current smoker": How soon after you wake up do you smoke your first cigarette?

O within 5 minutes O 6-30 minutes O 31-60 minutes
O after 60 minutes

If "current smoker": How often do you smoke cigarettes?

O every day O some days O but not every day

Alcohol Screening

Did you have a drink containing alcohol in the past year?

O Yes O No

If Yes:

How many drinks did you have on a typical day when you were drinking in the past year?

O 1 or 2 drinks O 3 or 4 drinks O 5 or 6 drinks
O 7 to 9 drinks O 10 or more

If Yes:

How often did you have a drink containing alcohol in the past year?

O Never O Monthly or less O 2 to 4 times a month
O 2 to 3 times a week O 4 or more times a week

Drug Screening

Have you used drugs other than those for medical reasons in the past 12 months? O Yes O No

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Family History-Please check all that apply to your family medical history. ☐ CHECK BOX IF FAMILY HX IS UNKNOWN
Please indicate Maternal (M) or Paternal (P) relationship in space provided for Grandmother, Grandfather, Uncle and Aunt.

☐	Colon Cancer	Mother	Father	Brother	Sister	Grandmother ____	Grandfather____	Uncle____	Aunt____
☐	Colon polyps	Mother	Father	Brother	Sister	Grandmother ____	Grandfather____	Uncle____	Aunt____
☐	Rectal or Anal Cancer	Mother	Father	Brother	Sister	Grandmother ____	Grandfather____	Uncle____	Aunt____
☐	Gastric cancer	Mother	Father	Brother	Sister	Grandmother ____	Grandfather____	Uncle____	Aunt____
☐	Pancreatic cancer	Mother	Father	Brother	Sister	Grandmother ____	Grandfather____	Uncle____	Aunt____
☐	Breast Cancer	Mother	Father	Brother	Sister	Grandmother ____	Grandfather____	Uncle____	Aunt____
☐	Ovarian Cancer	Mother	Sister	Grandmother____	Aunt____				
☐	Uterine/Endometrial Cancer	Mother	Sister	Grandmother____	Aunt____				
☐	Ulcerative colitis	Mother	Father	Brother	Sister	Grandmother ____	Grandfather____	Uncle____	Aunt____
☐	Liver disease	Mother	Father	Brother	Sister	Grandmother ____	Grandfather____	Uncle____	Aunt____
☐	Diabetes	Mother	Father	Brother	Sister	Grandmother ____	Grandfather____	Uncle____	Aunt____
☐	Coronary artery disease	Mother	Father	Brother	Sister	Grandmother ____	Grandfather____	Uncle____	Aunt____
☐	Crohn's Disease	Mother	Father	Brother	Sister	Grandmother ____	Grandfather____	Uncle____	Aunt____

Medications: **List all medications you presently take. Also please list any blood thinning medications (aspirin, Plavix, Coumadin, fish oil, Vitamin E, cardiotabs)** Please use separate page if needed

NAME OF MEDICATION	Dosage	Reason for taking Medication

Allergies:

Drug/Agent	Reaction

Patient Signature:_____ **Patient Name:**_____

Date:_____