Bay Area Advanced Gastroenterology Care

Ramesh N. Ashwath, MD, FACG
Board Certified in Gastroenterology
1130 Kyle Wood Lane Brandon, FL 33511
TEL 813-600-5423 FAX 678-553-1277

Patient Information

Name: _____ D.O.B. _____Age: _____

Address: _____City: _____ Zip: _____

Home Phone: _____Cell: _____ Work: _____

Social Security: _____ Sex (Circle One): Female/Male/_____Circle one: M/S/D/WID

Race (Circle One): Hispanic, African or African American, Native American or Alaskan, Native Hawaiian or Pacific Islander, Caucasian, Asian, or European American

Emergency Contact:

Name: _____ Phone: _____ Relation: _____

Primary Physician: _____ Phone: _____ Fax: _____

Pharmacy name: _____ Phone: _____

EMAIL for patient portal: _____
We will obtain a copy of your insurance and ID card.

I hereby authorize direct payment of any medical/surgical benefits to Dr. Ashwath, for services rendered by him/or his staff in person or under his supervision, whether these services were received in the office, hospital or ambulatory setting. I understand that I am financially responsible for any balance that is allowed but may not be covered by my insurance company.

Authorization to release medical information

I hereby authorize any hospital/ambulatory facility/laboratory or physician's office to release my medical records to Dr. Ashwath for continuing medical treatment with him. I hereby authorize Dr. Ashwath or his staff to release any medical or incidental information about me that maybe necessary for either my medical care or in processing applications for financial benefits.

Medicare/Medicaid

I certify that the information given by me in applying for payments if correct. I authorize release of all medical records/information or request, either by Dr. Ashwath, his staff or the Medicare and or Medicaid offices. I request that payment of all authorized benefits be made on my behalf to Dr. Ashwath.

A photocopy of these assignments shall be as valid as the original signature.

Patient/Guardian Signature: _____ Date: _____

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Authorization to Share "Protected Health Information"

The purpose is to permit Dr. R. Ashwath and/or his staff to share/discuss and/or give copies of your personal protected health information. Identifying info, name, address, age, gender, (etc.), past/future office, outpatient procedure appointments, results of any testing or further testing, billing, balances of account, copayments, deductibles, to speak with the following people as if he/or his staff were speaking with me (the patient). I understand that the people listed may not be required to comply with federal health information privacy laws and may use further disclose any and all of my protected health information (medical records) they receive.

Please give us the person(s) with whom your medical information may be shared with, if none, write none.

Name: _____ Phone: _____ Relation: _____

Name: _____ Phone: _____ Relation: _____

Name: _____ Phone: _____ Relation: _____

Do you want this authorization to expire? _____ If so, when? _____

Patient Consent for the Use and Disclosure of Protected Health Information

With my consent, Dr. R. Ashwath and staff may use and disclose protected health information about me to carry our treatment, payment, and healthcare operations of his office. Please refer to Dr. R. Ashwath's notice of privacy practices for a more complete description of such uses and disclosures. These disclosures may also be faxed for the purpose of TPO. I have their right to review the notice of privacy practices prior to signing this consent Dr. Ashwath resources the right to revise its notice of privacy practices may be obtained by forwarding a written request to Dr. Ashwath's privacy officer at the address above. With my consent, Dt. Ashwath of staff may call my home or any other number that has been given to his office, leave a voicemail, on answering machine or cell phone, ETC or with a relative or in person reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurances items, and any call pertaining to my clinical care, including laboratory/blood results among others. With my consent Dr. Ashwath and staff may mail to my home or office or other designated location any items that assist the practice in carrying out TPO, such as reminders, billing statements, faxing is also permitted, as well as emailing, I also have the right to request that Dr. Ashwath restrict how it uses or discloses my PHI to carry out TPO however the practice is not required to agree to my requested restrictions, but if it does is bound by this agreement.

By signing this form, I am consenting to Dr. Ashwath's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Dr. Ashwath may decline to provide treatment to me.

Signature: _____ Date: _____

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Cancellation/No show policy for Appointments & Procedures

1. ***Cancellation/ No show Policy for Appointment***
   We understand that there are times when you have to miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment.
   If an appointment is not cancelled at least 24 hours in advance you will be charged a twenty-five dollar ($25) fee; this will not be covered by your insurance company.

2. ***Scheduled Appointments***
   We understand that delays can happen, however we must try and keep the other patients and doctor on time.
   If a patient is 15 minutes past their scheduled time, we will have to reschedule the appointment.

3. ***Cancellation/No show policy for Procedures***
   Due to the large block of time needed for procedures, last minute cancellations can cause problems and added expenses for the office.
   If a procedure/surgery is not cancelled at least 7 days in advance you will be charged a one hundred dollar ($100) fee; this will not be covered by your insurance company.

4. ***Account Balances***
   We will require that all patients' balances on their account be zero (0) prior to receiving any further services by our practice.
   Patients who have questions about their bills or who would like to discuss a payment plan option may call billing at 727-771-1300 and ask to speak with whom they can review their account and concerns.

_____	_____	_____
Print name Patient	**Signature Patient/Guardian**	**Date**

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Authorization to release medical information

PATIENT NAME: _____ DATE OF BIRTH:_____

PHONE NUMBER: _____ADDRESS:_____

CITY/STATE/ZIP: _____

I authorize the following physician person facility/entity;

Name: _____

Address: _____ _____

City/State/Zip: _____

Tel number: _____ Fax number: _____

To Please Release my protected health information to the following physician or facility

BAYAREA ADVANCED GI CARE

1130 KYLE WOOD LANE BRANDON FL 33511

OFFICE NUMBER: 813-600-5423 OFFICE FAX: 678-553-1277

The information you may release subject to this signed release form is as follows:

- ☐ All Gastroenterology Treatment Records
- ☐ Other Records (please specify) _____

Patient Signature: _____ Date:_____

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Patient Medical History

Patient name: _____D.O.B_____

Reason for today's visit: _____

Symptom Check: Please check the symptom/s you currently have or have had in the past year.

___ Poor appetite	___ Bloating/Gas	___ Chest Pain
___ Bowel changes	___ Constipation	___ Stomach Pain
___ Diarrhea	___ Weight loss	___ Vomiting
___Vomiting Blood	___ Rectal Bleeding	___ Hemorrhoids
___ Indigestion	___ Nausea	___ Other

_____

_____

Do you Smoke?_____how often? _____Do you drink alcohol? _____how often? _____

Past Medical History:

_____

Surgical History:

_____

Any Immediate family history of cancer and what type? _____

Any Immediate family history of GI conditions? _____

Last colonoscopy & date? _____Any polyps? _____

Last Upper Endoscopy date? _____

Where & by whom were procedures performed? _____

MEDICATIONS you are currently taking:

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

ALLERGIES to medications or substances:

_____ _____ _____ _____