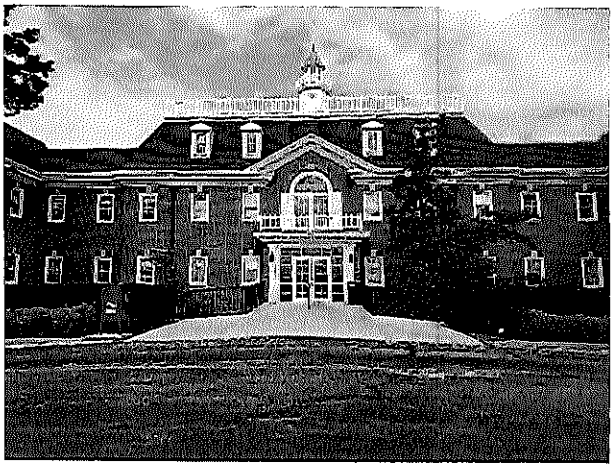
MIDWEST HEMORRHOID TREATMENT CENTER



2821 North Ballas Road, Suite 205
St. Louis, Missouri 63131
Office: 314-991-9888 Fax: 314-991-9886

Please Arrive **15 MINUTES PRIOR** To your scheduled appointment. Please bring **COMPLETED PAPERWORK**, your insurance card(s), and photo ID.

Failure to do so could result in the rescheduling of your appointment

Directions

Using GPS: "2821 North Ballas Rd, St. Louis, Missouri 63131" or "Town & Country Medical Building"

From Interstate 64/40: Exit 26 for Ballas Road South, continue towards Clayton Road. We are located on the northwest Corner of Ballas and Clayton Rd.

From Interstate 70: Exit 232/232B to merge onto I-270 South towards Memphis. Take exit 12A/12B for Ballas Road/I-64 east. Follow signs for Ballas Road, go south on Ballas Road and the office is located about one half mile on right.

From Interstate 55: Take exit for I-270 west towards Kansas City, Merge on to I-270 north. Take exit 12 for Interstate 64/40. Keep right and continue to exit 26, Follow signs for Ballas Road and the office is located about one half mile on right.

From Interstate 44: Take exit 279 to merge onto I-270 north, towards Chicago. Take exit 12 for Interstate 64/40. Keep right and continue to exit 26, Follow signs for Ballas Road and the office is located about one half mile on right.

Or click **Here** for directions

Patient Name: _____ DOB: _____ PLACE BARCODE HERE

Today's Date: _____

1. IDENTIFICATION

Name: _____
LAST *FIRST* *MIDDLE*

Preferred Name: _____

Legal Sex: F / M

DOB: ____/____/_____

SSN: ____-____-_____

2. CONTACT INFORMATION

Address: _____

_____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____-_____

Mobile Phone: (____) _____-_____

Consent To Text: ☐ Yes ☐ No

Work Phone: (____) _____-_____

Email: _____

(Emails received from MWHTC may state the practice name in the subject line)

Contact Preference:

☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Pt. Portal

3. DEMOGRAPHIC INFORMATION

We are required by government mandate to ask the following questions:
(Although you may refuse to answer)

Race: _____

Language: _____

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Marital Status:

☐ Married ☐ Partner ☐ Single
☐ Divorced ☐ Separated ☐ Widowed

Sexual Orientation: _____

Gender Identity: _____

Assigned Sex At Birth: _____

Preferred Pronouns: _____

4. ADDITIONAL INFORMATION

How did you hear about our practice?

-If you were referred by a physician, please include Name, Address, and Phone

_____

_____

_____

5. EMERGENCY CONTACT INFORMATION

Name: _____

Relationship to Patient: _____

Home Phone: (____) _____-_____

Mobile Phone: (____) _____-_____

6. PATIENT EMPLOYER INFORMATION

Employer Name: _____

Job/Position: _____

7. GUARANTOR INFORMATION ☐ *Self* (skip to section 8)

(Person responsible for your bills)

Relationship To Patient: _____

Name: _____
LAST *FIRST* *MIDDLE*

SSN: ____-____-_____ DOB: ____/____/_____

Primary Phone: (____) _____-_____

Email: _____

Mailing Address: ☐ *Same As Patient*

_____

_____

City: _____ State: _____ Zip: _____

8. PRIMARY CARE PHYSICIAN INFORMATION

Name: _____

Address: _____

_____

Phone: (____) _____-_____

Fax: (____) _____-_____

☐ I give MWHTC permission to share information regarding my care with my Primary Care Physician.

☐ **NO**, MWHTC *may not* share any information regarding my care with my Primary Care Physician

9. PHARMACY INFORMATION

Please provide the information for your LOCAL pharmacy, as most prescriptions we write are for immediate and temporary use

Name: _____

Address: _____

_____

Phone: (____) _____-_____

By signing this form, I acknowledge that parts 1 through 9 of this form have been completed with information that is true and accurate to the best of my knowledge.

Signature: _____ **Date:** ____/____/_____

Patient Name: _____ DOB: _____ PLACE BARCODE HERE

Today's Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I acknowledge I have had the opportunity to view a copy of Midwest Hemorrhoid Treatment Center's Notice of Privacy Practices. I understand I am responsible for reading this notice and for notifying Midwest Hemorrhoid Treatment Center, in writing, of any requests of restrictions on the use or disclosure of my personal health information (PHI). I understand Midwest Hemorrhoid Treatment Center will provide me with a copy of the Notice of Privacy Practices upon my request. Midwest Hemorrhoid Treatment Center has the right to revise this notice at any time and will make the updated version(s) available to me.

Patient Signature: _____ **Date:** _____

Parent/Guardian/Legal Rep. Signature: _____

1. Medication History Authority – SureScripts, Inc. is a prescription system allowing prescriptions and related information to be exchanged between your providers and pharmacy. The information sent between these systems may include details of prescription drugs you are currently taking and/or have taken in the past. This system will allow us to keep your medication list as updated as possible. *This authorization does NOT authorize MWHTC to discuss your medical care with anyone other than those permitted in section 4 and/or under applicable law.*

- **Allow MWHTC to retrieve medication history directly from your pharmacy using SureScripts?** ☐ YES ☐ NO

2. Automated Messaging Preferences – MWHTC uses an automated messaging service for appointment reminders, health notifications, and billing notifications.
-This system will *not* disclose details of your medical care.
-This system *will* disclose the name of our practice, physician, or both.
- If you choose to receive notifications via phone, the system *will* leave a voicemail message; if applicable, it *will* disclose your appointment date and time in the message
-This authorization does not give MWHTC permission to discuss your medical care with anyone other than those permitted in section 4 and/or under applicable law.

- **Please choose the format(s) in which you would like to receive notifications from MWHTC:**
(You may choose multiple formats for each notification type)

Health Notifications:	☐ Email	☐ Phone	☐ Text
Appointment Reminders:	☐ Email	☐ Phone	☐ Text
Billing Notifications:	☐ Email	☐ Phone	☐ Text

3. Patient Record Sharing – MWHTC uses electronic medical records software that has the capability to connect with all other medical providers who use the same software (aka: connected care locations). Utilizing the Patient Record Sharing feature means patient records are *automatically*, electronically shared back and forth with any connected care locations you have ever visited and granted Patient Record Sharing permission to. Any connected care locations to whom you have NOT granted this permission are exempt from receiving records from MWHTC even if you have granted this permission to MWHTC and vice versa.
** This does not give MWHTC permission to send records or correspondence of any kind to medical providers who are not part of the connected care network. In order for specific providers to receive records from our office, they must be listed in section 4 below.

- **Allow MWHTC to automatically share & receive medical records with connected care locations?** ☐ YES ☐ NO

4a. Authorization For Verbal/Written/Electronic Disclosure of PHI (With whom may we discuss your personal health information?) – In order to protect your privacy and maintain confidentiality, Midwest Hemorrhoid Treatment Center requires your written consent to release medical information to persons other than yourself via telephone, written correspondence, and/or electronic record sharing.

- **Below, please list the name(s) of anyone we have permission to speak with regarding your personal health information.**
Personal health information includes, but is not limited to diagnoses, medications, appointments, and plan of care.

NOTES:
-If you would like us to be able to speak to the person you listed as your Emergency Contact for any reason other than a medical emergency, you must list that person below.
-If you would like us to be able to correspond with any other healthcare providers, including your PCP, regarding your care at MWHTC, you must list those providers below.
-If we receive an inquiry regarding your PHI from a person not listed below, we will NOT be able to discuss anything with that person without you contacting us first.

Name: _____ **Relation:** _____ **Name:** _____ **Relation:** _____

Name: _____ **Relation:** _____ **Name:** _____ **Relation:** _____

4b. Authorization For MWHTC Employees To Leave Messages – Due to patient confidentiality, MWHTC must have permission in order for employees to leave detailed messages regarding appointments, prescriptions, procedures, etc. in the event that we are unable to speak to you directly at the time of our call.

- **May MWHTC leave messages regarding appointments, prescriptions, procedures, etc.?**

☐ **Yes,** MWHTC may leave voicemail messages on my home phone and/or cell phone or with one of the people listed above.

☐ **No,** MWHTC may **not** leave messages of any kind. MWHTC must speak to me personally.

Signature – BY SIGNING BELOW, I ACKNOWLEDGE I HAVE CAREFULLY READ AND FULLY UNDERSTAND THE AUTHORIZATIONS I HAVE GRANTED/DECLINED IN PARTS 1 THROUGH 4a,b OF THIS FORM. I UNDERSTAND THAT MWHTC WILL CONSIDER AN UNANSWERED SECTION TO BE A DECLINE OF THAT AUTHORIZATION.

PATIENT SIGNATURE: _____ **DATE:** _____

Patient Name: _____ DOB: _____ PLACE BARCODE HERE

Today's Date: _____

FINANCIAL POLICY

FINANCIAL RESPONSIBILITY

- I understand I am directly and primarily responsible for paying all charges incurred for services and procedures rendered at Midwest Hemorrhoid Treatment Center.
- I understand I am responsible for co-payments/co-insurance payments prior to provision of services.
- I understand the services and procedures provided to me may be applied to my deductible and I am responsible for payment of such services and procedures.
- I understand any discussion with Midwest Hemorrhoid Treatment Center regarding my total financial responsibility for services rendered is only an ESTIMATE. In the event my care exceeds the amount of the estimate, I will still be financially responsible for payment of the balance.
- I understand Midwest Hemorrhoid Treatment Center may file a claim for payment with my insurance company as required by contractual agreement. If my insurance company fails to pay Midwest Hemorrhoid Treatment Center in a timely manner or denies payment for any reason, I understand I will be responsible for prompt payment of all amounts owed to MWHTC.

* SHOULD THE ACCOUNT BE REFERRED TO A COLLECTION AGENCY OR ATTORNEY FOR COLLECTION, THE UNDERSIGNED PATIENT WILL BE RESPONSIBLE FOR A DELINQUENT PROCESSING FEE IN ADDITION TO ALL COSTS OF COLLECTION, INCLUDING REASONABLE ATTORNEY'S FEES, AND THE OUTSTANDING ACCOUNT BALANCE.

RESPONSIBILITY TO PROVIDE PROOF OF INSURANCE AND TO OBTAIN REFERRAL

- I understand it is my responsibility to provide Midwest Hemorrhoid Treatment Center with a copy of my current insurance card prior to receiving any service or procedure.
- I understand that if I fail to provide Midwest Hemorrhoid Treatment Center with current proof of insurance:
  - I may be considered a Self-Pay patient and will be financially responsible for payment in full for services rendered. (see 'INSURANCE WAIVER and NON-COVERED SERVICES WAIVER" below)
  - My appointment may be cancelled by MWHTC until I am able to provide proof of current insurance.
- I will notify Midwest Hemorrhoid Treatment Center immediately upon any changes related to my insurance company and/or coverage.
- I understand my insurance company may require a referral from my Primary Care Physician prior to being seen at Midwest Hemorrhoid Treatment Center, and I am responsible for contacting my insurance company to verify referral requirements.
- I understand Midwest Hemorrhoid Treatment Center is not obligated to see patients without a valid referral (if required) and has the right to cancel my appointment if I fail to provide a valid referral prior to or at the time of my scheduled appointment.

INSURANCE WAIVER and NON-COVERED SERVICES WAIVER

- I understand Midwest Hemorrhoid Treatment Center is NOT obligated to see me if I do not provide proof of current insurance and/or a valid referral, if required. If I still wish to be seen, I can be seen as a Self-Pay patient. I agree neither Midwest Hemorrhoid Treatment Center nor I will file a claim for services provided to me as a Self-Pay patient, and I will be required to pay the total cost at the time of service.
- I understand there may be services provided which are not covered by my insurance plan and I am responsible for payment of such non-covered services.
-If feasible, a waiver may be granted for Self-Pay patients and non-covered services.

ADDITIONAL FINANCIAL INFORMATION

Midwest Hemorrhoid Treatment Center accepts the following forms of payment:

- Cash
- Check
- Credit/Debit/HSA Card – Visa, MasterCard, Discover, and American Express

I understand additional charges may be applied to my account for any of the following reasons:

- Returned Checks (insufficient funds)
- Collection Services
- Administrative services not covered by insurance
- Certified Letters
- Interest on Outstanding Balances
- Broken Appointments (no call, no show)

MWHTC has the right to cancel any appointment to which the patient arrives more than 15 minutes late. Broken appt. fee applies.

ASSIGNMENT OF BENEFITS

-I hereby authorize my insurance company to direct all payment and benefit for services rendered directly to Midwest Hemorrhoid Treatment Center. In the event my insurance company pays me directly, I agree to forward that payment to Midwest Hemorrhoid Treatment Center.
- I hereby authorize Midwest Hemorrhoid Treatment Center to release to my insurance company all medical information necessary to obtain coverage for services rendered.
- I understand I am responsible for all charges not covered by my insurance plan.

SIGNATURE

BY SIGNING THIS FORM, I ACKNOWLEDGE I HAVE CAREFULLY READ, FULLY UNDERSTAND, AND AGREE TO THE ABOVE TERMS AND CONDITIONS.
I ACKNOWLEDGE THAT ANY ALTERATIONS MADE TO THIS FORM BY ME ARE VOID AND MY SIGNATURE REPRESENTS AGREEMENT TO THE ABOVE TERMS AS THEY WERE ORIGINALLY WRITTEN.

Patient Signature: _____ Date: _____

Patient Name: _____ DOB: _____ PLACE BARCODE HERE

Today's Date: _____

DRUG ALLERGIES: ☐ **No Known Drug Allergies**

Please List *ALL* Drug Allergies & Reactions: _____ _____ _____

_____ _____ _____

_____ _____ _____

MEDICATION: ☐ **None**

Please List *ALL* of Your Current Medications: _____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

ANAL/RECTAL PROBLEMS:

Regular Bowel Movements?	☐ No	☐ Yes	Frequency: _____
Anal or Rectal Pain?	☐ No	☐ Yes	
Anal or Rectal Bleeding?	☐ No	☐ Yes	Check All That Apply: ○ Bright Red ○ Dark Red ○ With Pain ○ Without Pain
Anal or Rectal Itching?	☐ No	☐ Yes	
Difficulty Controlling BMs?	☐ No	☐ Yes	

FAMILY HEALTH HISTORY *NOT including yourself:* ☐ ***Adopted*** ☐ ***No Significant Family History***

Colon/Rectal Cancer:	Family Member(s): Age at Onset: Age at Death (IF CAUSE):
Other Cancer: (SPECIFY TYPE FOR EACH)	Family Member(s): Type of Cancer: Age at Onset: Age at Death (IF CAUSE):
Colon Polyps:	Family Member(s): Age at Onset: Age at Death (IF CAUSE):
Hypertension:	Family Member(s): Age at Onset: Age at Death (IF CAUSE):
CAD/Heart Disease:	Family Member(s): Age at Onset: Age at Death (IF CAUSE):
CVA/Stroke:	Family Member(s): Age at Onset: Age at Death (IF CAUSE):
Clotting Disorder:	Family Member(s): Age at Onset: Age at Death (IF CAUSE):
Diabetes:	Family Member(s): Age at Onset: Age at Death (IF CAUSE):
Other:	Family Member(s): Age at Onset: Age at Death (IF CAUSE):

Patient Name: _____ DOB: _____ PLACE BARCODE HERE

Today's Date: _____

SOCIAL HISTORY:

Tobacco Smoking: ☐ Never ☐ Former: Years Used: _____ Amount/Day: _____ ☐ Current: Years Used: _____ Amount/Day: _____

Smokeless Tobacco: ☐ Never ☐ Former: Years Used: _____ Amount/Day: _____ ☐ Current: Years Used: _____ Amount/Day: _____
○ Snuff ○ Chew ○ Powdered

E-cigarette/Vape: ☐ Never ☐ Former ☐ Yes

Alcohol: ☐ Never ☐ Former ☐ Yes: ○ Occasional (Less than 1 drink/day) ○ Moderate (1-2 drinks/day) ○ Heavy (More than 2 drinks/day)

Caffeine: ☐ Never ☐ Former ☐ Yes: Type: _____ Amount/Day: _____

Drug Use: ☐ Never ☐ Former ☐ Yes: Type: _____

The CDC has reported that some types of synthetic marijuana are known to cause excessive bleeding. It is important that we know of any synthetic marijuana use, past or present. Have you ever used SYNTHETIC marijuana? ☐ Never ☐ Yes: How Recently: _____

Patients 65 or Older: Do you have an Advance Directive in place? ☐ No ☐ Yes

SURGICAL HISTORY: ☐ **No To All**

☐ Colonoscopy – How many? _____ Date of Most Recent: _____ Result: _____ Date of Next: _____

	Date/Most Recent
☐ Hemorrhoidectomy	
☐ Hemorrhoid Banding	
☐ Fissure Surgery	
☐ Fistula Repair	
☐ Pilonidal Cystectomy	
☐ Polypectomy	
☐ Drainage of Abscess	
☐ Colectomy	
☐ Colostomy	
☐ Small Bowel Resection	
☐ Rectal Prolapse Repair	
☐ Hip Replacement	
☐ Knee Replacement	
☐ Neck/Back Surgery	

☐ Excision of Skin Cancer Lesion – Type: _____
☐ Tonsillectomy
☐ Appendectomy
☐ Gallbladder Removal
☐ Hernia Repair
☐ Bariatric Surgery
☐ Abdominoplasty
☐ Organ Transplant – Type: _____
☐ Pulmonary Lobectomy
☐ Thyroidectomy
☐ Cardiac Pacemaker – Serial #: _____
☐ Cardiac Defibrillator – Serial #: _____
☐ Coronary Artery Bypass (CABG)
☐ Heart Valve Replacement
☐ Stent(s)
☐ Bladder Surgery
☐ Other: _____

Female Specific:
☐ Mastectomy ○ Rt ○ Lt ○ BIL
☐ Lumpectomy
☐ Caesarian Section – How many? _____
☐ Hysterectomy ○ Partial ○ Total
☐ Oophorectomy ○ Rt ○ Lt ○ BIL
☐ Salpingectomy ○ Rt ○ Lt ○ BIL
☐ Vaginal Prolapse Repair

Male Specific:
☐ Mastectomy ○ Rt ○ Lt ○ BIL
☐ Lumpectomy
☐ Prostatectomy
☐ Prostate Radiation
☐ Orchiectomy ○ Rt ○ Lt ○ BIL

FEMALE PATIENTS ONLY: Are you currently pregnant? ☐ Yes ☐ No ☐ Possibly

Number of Pregnancies: _____ Number of Vaginal Deliveries: _____ Number of C-Sections: _____

Complications:
Accidental Bowel Leakage POST Delivery? ☐ Yes ☐ No ☐ Unknown Surgical Episiotomy During Delivery? ☐ Yes ☐ No
Tear or Laceration During Delivery? ☐ Yes ☐ No

Date of Most Recent Mammogram: _____ Date of Most Recent Pap Smear: _____

Patient Name: _____ DOB: _____ PLACE BARCODE HERE

Today's Date: _____

PAST MEDICAL HISTORY: ☐ No To All

- ☐ Accidental Bowel Leakage
- ☐ Anal/Rectal Trauma/Injury
- ☐ Anemia
- ☐ Aneurysm
- ☐ Anxiety Disorder
- ☐ Arthritis/Gout
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Autoimmune Disease: _____
- ☐ Bleeding Disorder: _____
- ☐ COPD
- ☐ Cancer: _____
- ☐ Cardiac Dysrhythmia
- ☐ Cataracts
- ☐ Celiac Disease
- ☐ Colon/Rectal Polyps
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ Crohn's Disease
- ☐ Deep Vein Thrombosis
- ☐ Depression
- ☐ Diabetes – Type _____
  *Most Recent Eye Exam: _____ Result: _____
- ☐ Diverticulitis
- ☐ Diverticulosis
- ☐ Genital Herpes
- ☐ Genital Warts
- ☐ Glaucoma
- ☐ HIV/AIDS (CONFIDENTIAL)
- ☐ Head Trauma
- ☐ Headaches/Migraines
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Hernia
- ☐ High Cholesterol
- ☐ Hypertension (High Blood Pressure)
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Irritable Bowel Syndrome
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Liver Disease/Hepatitis: _____
- ☐ MRSA/VRE Exposure
- ☐ Mitral Valve Prolapse
- ☐ Pulmonary Embolism
- ☐ Reflux/GERD
- ☐ Seizures/Epilepsy
- ☐ Sleep apnea
- ☐ Stroke
- ☐ Ulcerative Colitis
- ☐ Other: _____

REVIEW OF SYSTEMS: CHECK ALL THAT CURRENTLY APPLY OR ☐ No To All

Constitutional:
- ☐ Fever
- ☐ Night Sweats
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Chills

ENMT:
- ☐ Difficulty Hearing
- ☐ Sinus Problems
- ☐ Snoring
- ☐ Mouth Ulcers

Cardiovascular:
- ☐ Chest Pain on Exertion
- ☐ Arm Pain on Exertion
- ☐ Shortness of Breath – Walking
- ☐ Shortness of Breath – Lying Down
- ☐ Palpitations
- ☐ Known Heart Murmur

Respiratory:
- ☐ Cough
- ☐ Wheezing
- ☐ Shortness of Breath
- ☐ Coughing Up Blood

Gastrointestinal:
- ☐ Abdominal Pain
- ☐ Nausea/Vomiting
- ☐ Constipation
- ☐ Change in Appetite
- ☐ Black/Tarry Stool
- ☐ Frequent Diarrhea
- ☐ GERD

Genitourinary:
- ☐ Loss of Control
- ☐ Difficulty Urinating
- ☐ Hematuria

Musculoskeletal:
- ☐ Muscle Weakness
- ☐ Joint Stiffness/Pain
- ☐ Back/Neck Pain
- ☐ Difficulty Walking

Integumentary:
- ☐ Rash
- ☐ Itching
- ☐ Growths/Lesions

Neurologic:
- ☐ Weakness
- ☐ Numbness
- ☐ Seizures
- ☐ Dizziness
- ☐ Tremors

Psychiatric:
- ☐ Depression
- ☐ Alcohol Abuse
- ☐ Anxiety
- ☐ Suicidal Thoughts
- ☐ Dementia

Endocrine:
- ☐ Fatigue
- ☐ Increased Thirst
- ☐ Cold Intolerance

Hematologic/ Lymphatic:
- ☐ Swollen Glands
- ☐ Easy Bruising
- ☐ Excessive Bleeding