Gastroenterology Specialist of the Treasure Coast, INC

Jayshree Matadial, MD

501 NW Lake Whitney Place, Suite 102

Port St. Lucie, FL 34986

Ph (772) 337-3914 Fax (772) 337-3917

Initial Patient Visit

Name of Patient _____ DOB _____

Social Security # _____ Phone _____

Primary MD _____ Referring MD _____

What is your **Chief Complaint?** _____

Medical/Surgical History: List all medical Problems and all surgeries you have had.

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Family History: Please list any relevant illnesses for the following relatives, including age as well.

Relative	**Illness**	**Alive or Deceased**
Father	_____	_____
Mother	_____	_____
Children/Siblings	_____	_____
Other	_____	_____

Smoking History:

Do you smoke? _____ Y _____ N

How much? _____ / day

Quit _____ Y _____ N, When ____

Alcohol History:

Do you drink Alcohol? ____ Y ____ N

How much? _____ / day

Quit _____ Y _____ N, When _____

Medical/Surgical History: List all your medications including both prescription and non prescription medications. Use back of page if more space is required.

	Medication	**Dosage**	**Reason**
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____
9.	_____	_____	_____

Medication Allergies: List all medications you are allergic to and type of reaction. Include both prescription and non prescription medications. Use back of page if needed.

	Medication	**Type of Reaction**
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

To the best of my knowledge, the above information is complete and correct.

_____ _____

Patient signature, guardian, personal representative Date

_____ _____

Print Name Relationship to patient

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Patient Information

Name _____ DOB _____

Address _____ City/State/Zip _____

SSN _____ Marital Status: ____M ____D ____Single ____Other

Home # _____ Work # _____ Cell # _____

Email _____ Driver License # _____

Employer _____ Occupation _____

Emergency contact/relationship _____ Ph # _____

Primary Care Doctor _____ Ph # _____

Insurance Information

Primary Insurance _____

Name of Insured (self, spouse, parent) _____ SSN_____

DOB of Insured _____ Group # _____ Policy # _____

Phone # of Insurance _____

Secondary Insurance (if applicable) _____

Name of Insured _____ SSN_____

DOB of Insured _____ Group # _____ Policy # _____

Phone # of Insurance _____

Have you ever been seen by Dr. Matadial at the Heart and Family Health Institute/St. Lucie Medical Specialists? _____ If yes, with your signature you confirm that you have come to this office unsolicited by Dr. Matadial. X _____

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PATIENT CONSENT FOR TREATMENT AND AUTHORIZATION

Patient Name _____ **Date of Birth** _____

Social Security # _____ **Date** _____

I voluntarily give my permission to Dr. Jayshree Matadial, Gastroenterologist and her staff, to perform any and all necessary medical and surgical services in the management of my care. I understand that by signing this form, I am authorizing Dr. Jayshree Matadial to treat me while under her expressed care or until I withdraw my consent.

I give permission to Dr. Jayshree Matadial to release any medical information acquired in the course of my medical care to parties requesting information for coordination of my medical care, payment, utilization review, and coverage determination.

I authorize payment to be paid directly to Gastroenterology Specialist of the Treasure Coast, Dr. Jayshree Matadial, for all services rendered to me by Dr. Jayshree Matadial and for which services are covered benefits under my insurance plan(s).

I acknowledge that Gastroenterology Specialist of the Treasure Coast, Dr. Jayshree Matadial, will submit claims to my insurance company for services rendered. I acknowledge and agree that I will pay any charges which are not paid by my insurance carrier. if it becomes necessary to refer my account to a collection agency, I also acknowledge responsibility for applicable collection fees.

I understand there will be a $25.00 fee for any returned check per check returned.

A duplicate or faxed copy of this form constitutes the same as the original document.

_____

Signature of Patient or Legal Representative Date

_____

Printed Name of Patient or Legal Representative Relationship to Patient

_____

Witness Signature Date

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Acknowledgement of Notice of Privacy Practices

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patient's consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment, or health care operations, in order to provide health care that is in your best interest. We also want you to know that we support your full access to your personal medical records.

We may have indirect treatment relationships with you (such as laboratories, radiology centers, and surgery centers that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use of disclosure f your Personal Health Information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

By signing below, you acknowledge the above information and consent to our Notice of Privacy Practices and understand that Gastroenterology Specialist of the Treasure Coast, Inc. reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all the protected health information resident at, or controlled by, this practice. If changes to the policy occur, this practice will provide you with a revised Notice of Privacy Practices upon request.

If there are any other people besides yourself that are allowed to receive clinical information about you, please list them below:

Name Relationship Date of Birth

1. _____

2. _____

3. _____

_____

Name of Patient (Please Print) Date of Birth

_____

Signature of Patient or Patient Representative Date of Signature

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ACKNOWLEDGEMENT OF "ABUSE FREE ZONE"

At Gastroenterology Specialist of the Treasure Coast, we appreciate and respect our staff. It is our belief that our staff should have a work environment free from any form of verbal or physical abuse. We expect each one of our patients to treat each one of our staff members as you would like to be treated. Outbursts against any of our staff members will not be tolerated and may result in your **discharge** from this practice.

My signature below indicates that I agree to abide by the above "abuse free environment" policy.

_____ _____

Signature of Patient or Legal Representative Date