

Phone (816)941-0800 Fax (816)941-0080

<u>Leawood</u>	<u>Northland</u>	<u>Independence</u>	<u>Lee's Summit</u>
4370 W 109 th St Ste 350 Overland Park, KS 66211	6060 N. Oak TRFY Ste101 Gladstone, MO 64118 Park in Back of Building	19550 E 39 th St Ste 110 Independence, MO 64057 Centerpoint Medical Center	1980 SE Blue Parkway Ste 2330 Lee's Summit, MO 64063 Lees Summit Medical Bld 2

- 1. Please print, complete, and sign these forms.**
- Please bring the completed paperwork with you to your appointment.
- 3. Bring your insurance card(s) and a photo I.D.**
- If you have had a colonoscopy recently, please bring a copy of the current report.
- If referred to our practice, please make sure all necessary medical records including labs, radiology studies and office notes are faxed to our office prior to your scheduled appointment.
- 6. 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 separately from your office visit.**
- If you are unable to print this paperwork or complete prior to appointment, **please arrive 20 minutes prior to your appointment time** so that paperwork can be completed in office and make sure to bring a complete medication list and surgical history with you to the appointment.

Lina O'Brien, MD | Benyamine Mizrahi, MD | Jeremy Cravens, MD

Darcy Shaw, MD | Robert Kress, DO | Stephanie Peters, MD

Ann Barela, NP | Nicole Zwick, NP | Vivian Chen, NP | Suzanna Wilson, NP



Patient Name: _____ Title _____ Previous Name(s): _____

Home Address: Street: _____
City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Circle where messages can be left: HOME CELL WORK

Email: _____

Primary Care Physician First and Last Name: _____

Referring Provider First and Last Name (if applicable): _____

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

Language: English Spanish Indian Japanese Chinese Korean Other _____

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 - 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

INSURANCE INFORMATION

Do you have insurance? ☐ Yes or ☐ No **Do you have a secondary insurance?** ☐ Yes or ☐ No

****Please provide ALL insurance cards to the front desk****

Primary Insurance Name: _____

Policy/ID #: _____ Group #: _____

Subscriber name: _____ Phone# _____ DOB: _____

SS#: _____ Gender: F M

Secondary Insurance Name: _____

Policy/ID #: _____ Group #: _____

Subscriber name: _____ Phone# _____ DOB: _____

SS#: _____ Gender: F M

GENERAL CONSENT TO TREAT

I understand that I have the right be informed about my condition and the recommended surgical, medical or diagnostic procedure to be used so that I 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 my 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).

I consent to reasonable and necessary medical examinations, testing and treatment, which may include testing for communicable diseases such as HIV or AIDS. By signing below, I am indicating that (1) I intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) I 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. I have the right at any time to discontinue services.

I have the right to discuss the treatment plan with my healthcare clinician about the purpose, potential risks and benefits of any test ordered for me. If I have any concerns regarding any test or treatment recommend by my healthcare clinician, I am encouraged to ask questions. 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 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 consent to allowing residents and other supervised individuals enrolled in a healthcare professional education program as part of their training in health care education to participate in and/or observe the delivery of my medical care and treatment.

CONSENT TO TREATMENT USING TELEMEDICINE

I consent to treatment involving the use of electronic communications ("Telemedicine") to enable health care providers at different locations to share individual patient medical information for diagnosis, therapy, follow-up, and/or education purposes. I consent to forwarding my information to a third party as needed to receive Telemedicine services, and you understand that existing confidentiality protections apply. I acknowledge that while Telemedicine can be used to provide improved access to care, as with any medical procedure, there are potential risks and no results can be guaranteed or assured. These risks include, but are not limited to: technical problems with the information transmission or equipment failures that could result in lost information or delays in treatment. I understand that you have a right to withhold or withdraw my consent to the use of Telemedicine in the course of my care at any time, without affecting my right to future treatment and without risking the loss or withdrawal of any program benefit to which you would otherwise be entitled.

SHARED ELECTRONIC SYSTEM

This location uses an Electronic Health Record that will update all demographics/contact information to all our affiliated locations which share an electronic health record for which I have a relationship.

My consent to access the location's Electronic Health Record's Patient Portal shall be considered separate and apart from the consent in this form.

OPEN PAYMENTS DATABASE

The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars (\$10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public. The Open Payments database is a federal tool used to search payments made by drug and device companies to physician and teaching hospitals. It can be found at <https://openpaymentsdata.cms.gov>.

USE OF ARTIFICIAL INTELLIGENCE

I understand that treatment, processes, and certain related functions of the location may involve the use of artificial intelligence-enabled or -enhanced technologies, including for example analysis of large data sets in order to identify and predict patterns and/or systems that can abstract and process information automatically (collectively, "Artificial Intelligence"). Such treatments, processes, and related functions may also involve processes, procedures, or reports that are assisted by Artificial Intelligence. The location uses Artificial Intelligence systems as part of their commitment to improving treatments, processes, and related functions, which can help increase accuracy, reliability, speed, and safety of services.

FINANCIAL AGREEMENT

I understand that the location may bill an insurance company offering coverage. Regardless, in consideration for the services rendered and except where prohibited by law, I (the Patient or Guarantor) agree to pay for services that are not covered and covered charges not paid in full by insurance coverage including, but not limited to, coinsurance, deductibles, non-covered benefits due to policy limits or policy exclusions, or failure to comply with insurance plan requirements. I understand that in the event any amounts paid by me are ultimately greater than my final patient responsibility, such amounts may be applied to patient responsibility on other unresolved accounts prior to refund. I understand that while an estimate may have been provided prior to services, estimates may vary significantly from final charges based on a variety of factors. An itemized billing statement is available upon request and free of charge.

If supplies and services are provided to Patient who has coverage through a governmental program or through certain private health insurance plans, the location may accept a discounted payment for those supplies and services. In this event any payment required from the Patient or Guarantor will be determined by the terms of the governmental program or private health insurance plan. If the Patient is uninsured and not covered by a governmental program, the Patient may be eligible to have his or her account discounted or forgiven under the location's uninsured discount or charity care programs in effect at the time of treatment. I understand that I may request information about these programs from the location.

ASSIGNMENT OF BENEFITS

I assign all my rights and benefits under existing policies of insurance providing coverage and payment for any and all expenses incurred as a result of services and treatment rendered by the Provider and authorizes direct payment to the Provider of any insurance benefits otherwise payable to or on behalf of Patient. I understand that any health insurance policies under which I am covered may be in addition to other coverage or benefits or recovery to which I may be entitled, and that Provider, by initially accepting health insurance coverage, does not waive its rights to collect or accept, as payment in full, any payment made under different coverage or benefits or any other sources of payment that may or will cover expenses incurred for services and treatment.

I agree to take all actions necessary to assist the Provider in collecting payment from any such

Responsible Party should the Provider(s) elect to collect such payment, including allowing the Provider(s) to bring suit against the Responsible Party in my name. If I receive payment directly from any source for the medical charges associated with my treatment acknowledge that it is my duty and responsibility to immediately pay any such payments to the Provider(s).

I hereby irrevocably appoint the Provider as my authorized representative to pursue any claims, penalties, and administrative and/or legal remedies for any and all benefits due me for the payment of charges associated with services and treatment rendered by the Provider. These authorized actions include administrative and non-administrative appeals of any denial or underpayment of benefits or coverage, litigation, other forms of dispute resolution in any forum or for any type of relief (including monetary and equitable) available under applicable laws, including without limitation all provisions of the Employee Retirement Income Security Act of 1974, on my behalf against any responsible payer, employer-sponsored medical benefit plans, third party liability carrier or, any other responsible third party ("Responsible Party"). I also transfer and assign to the Provider all of my rights to demand and receive the production of or access to any documents or information, including without limitation, copies of health plan documents and materials, from any entity or person to the fullest extent of my rights to do so under my health plan and applicable laws. The foregoing rights are assigned in their entirety without limitation and without reservation of any part or aspect thereof. This assignment shall not be construed as an obligation of the Providers to pursue any such right of recovery. I acknowledge and understand that I maintain my right of recovery against my insurer or health benefit plan and the foregoing assignment does not divest me of such right.

MEDICARE PATIENT CERTIFICATION AND ASSIGNMENT OF BENEFIT

I certify that any information I provide in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to the clinic by the Medicare or Medicaid Program.

THIRD PARTY COLLECTION

I acknowledge location may use the services of a third-party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

CONSENT TO PHOTOGRAPHS, VIDEO, AND DIGITAL/AUDIO RECORDINGS

I acknowledge that the location security, quality improvement, patient care, healthcare operations and/or risk management activities may involve photographs, video, digital or audio recordings, and/or other images of me, including telephone calls, being recorded and consent to such images and recording. I understand that the location retains the ownership rights to the images and/or recordings. Images and/or recordings in which I am identified will only be used and disclosed as permitted by law.

ACKNOWLEDGEMENT OF NOTICE OF PATIENT RIGHTS AND RESPONSIBILITIES

I have been furnished with a Statement of Patient Rights and Responsibilities ensuring that I am treated with respect and dignity and without discrimination or distinction based on age, gender, disability, race, color, ancestry, citizenship, religion, pregnancy, sexual orientation, gender identity or expression, national origin, medical condition, marital status, veteran status, payment source or ability, or any other basis prohibited by federal, state, or local law.

I also understand that I have certain responsibilities as providing complete health history and treating the clinicians and staff with respect and consideration.

WEAPONS/DRUGS/EXPLOSIVES

I understand and agree that if the location at any time believes there may be a weapon, explosive device, illegal substance or drug, or any alcoholic beverage on my person or with my belongings, the location may call law enforcement authorities.

USE AND DISCLOSURE OF INFORMATION

I consent to Providers using and disclosing health information about me for purposes of treatment, payment, healthcare operations, public health and other purposes permitted by applicable law. Information covered by this consent specifically includes, without limitation, history and physical records, emergency records, laboratory reports, physician progress notes, nurse notes, discharge summaries, immunization records, genetic information, psychological information, psychiatric information, intellectual disability information, and information about substance abuse disorder and chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS. This consent applies, without limitation, to uses and disclosures for coordinate care or for case management purposes; to any person or entity liable for or involved in payment on Patient's behalf including to verify coverage; and to my employer's designee when the services delivered are related to a worker's compensation claim. If I am covered by Medicare or Medicaid, I authorize the release of my 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. Provider participates, or may in the future participate, in Health Information Exchanges (HIEs), data or immunization registries, or other organizations with healthcare providers, insurers, public health agencies, immunization registry users, and/or other health care industry participants and their subcontractors in order to share health information for treatment, payment, health care operations and other purposes permitted by law. Unless I notify Provider in writing that I desire to opt out of participation, I consent to health information about me being shared with participants in HIEs and other organizations as described above. Although I may opt out of immunization registries in some states, I agree that Provider may share my information with immunization registries.

NOTICE OF PRIVACY PRACTICES

(Patient/Representative initials) I acknowledge that I have received the location's Notice of Privacy Practices, which describes the ways in which the Provider may use and disclose my health information. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint.

CONSENT TO TELEPHONE CALLS, EMAIL, OR TEXT MESSAGE

(Patient/Representative initials) By opting in to receiving texts and emails, I authorize the use of any email address or telephone number I provide (including email addresses or telephone numbers that I provide for my family or designated representatives) (whether wireless or a landline and including email addresses and telephone numbers forwarded or transferred from provided information), if you consent to patient reminders and other healthcare texts and emails, to receiving information from HCA Healthcare and its affiliates and service providers ("HCA") relating to my healthcare services and financial obligations, including, but not limited to: (I) healthcare-related information, including appointment reminders, treatment and follow-up instructions, dietary information, prescription information, referrals, insurance or health plan eligibility or coverage, information about my condition(s), diagnosis, treatment plan, available treatment options and capabilities, programs or services that might be of interest to me,

invitations to participate in surveys, reviews or evaluations of my experience(s), instructions for how to access my information, or inquiries regarding my preferences; and (ii) financial communications, including without limitation, financial assistance and benefits screening, payment reminders, delinquent notifications, instructions, and links to Patient billing information. If you consent to marketing texts and emails, you also authorize the use of the email address and telephone number I provide to receive marketing and promotional materials that may be of interest to you from HCA.

I expressly agree and consent that HCA may contact me by telephone, on a recorded line, using pre-recorded or artificial voice messages, and/or using automated dialing technology. I represent (if I am not the patient) that I am authorized by the patient to receive calls, text messages or email messages on their behalf and that I am involved in assisting in the patient's care and/or payment I represent that I am the account holder for any telephone number(s) that I may provide and am responsible for notifying Provider of any changes or updates to such telephone number(s).

I understand that emails and text messaging may be unencrypted and that there is some risk that information included in unencrypted messages, including email and text messages, may be intercepted or received by unintended third parties and/or stored or archived by our service providers and system operators. Information included in such messages may include your name, date/time of appointments, physician/location name, physician/practice specialty, patient account number or other information related to your financial obligation or our services. Message frequency may vary, and message and data rates may apply to text messages. Additional text messaging terms may be located on HCA's website and may be updated from time to time. I understand I can withdraw my consent at any time. To stop receiving a certain text message type (e.g., subsequent messages about my treatment plan), I understand that I can follow the opt-out instructions included in the message, but I may continue receiving text messages of other types subject to separate opt-out procedures.

I understand that consent is not a condition of me receiving any healthcare services. For more information, please review the [Notice of Privacy Practices](#) and [Terms of Use](#).

COMMUNICATIONS ABOUT MY HEALTHCARE/ DISCLOSURES TO FRIENDS AND/OR FAMILY MEMBERS

I authorize my healthcare information to be disclosed for purposes of communicating results, findings, and care decisions to my family members and others I designate to be responsible for my care (see below). I agree I may be contacted by the Provider or an agent of the Provider or an independent physician's office for the purposes of scheduling necessary follow-up visits recommended by the treating physician.

I have the option to designate a family member or another individual with whom the provider is authorized to discuss your medical condition. By listing such individuals below, I grant permission for your Protected Health Information (PHI) to be disclosed to them for the purpose of communicating medical results, findings, and care-related decisions. In the future, I (Patient/Representative) may revoke or modify this specific authorization and that revocation or modification must be in writing.

Please designate specific people or indicate "none".

	Name	Relationship	Contact Number
1:			
2:			
3:			

PRESCRIPTION ORDER PICK UP

I may need a friend or family member to pick up a prescription order (script) from this location. In order to release a prescription script to my designee, this location will need to have a record of their name. Prior to release of the script, my designee will need to present valid picture identification and sign for the prescription.

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

Name	Relationship to Patient

OR

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

ACKNOWLEDGEMENT

I have been given the opportunity to read and ask questions about the information contained in this form, specifically including but not limited to the financial obligation's provisions and assignment of benefit provisions, and I acknowledge that I either have no questions or that my questions have been answered to my satisfaction and that I have signed this document freely and without inducement other than the rendition of services by the Providers. I have received no promises, assurances, or guarantees from anyone as to the results that may be obtained by any medical treatment or services. If insurance coverage is insufficient, denied altogether, or otherwise unavailable, the undersigned agrees to pay all charges not paid by the insurer.

If I am signing as legal guardian, I acknowledge and verify that I am the legal guardian or custodian of the minor/incapacitated patient.

Patient/Representative
PRINT NAME (please write legibly)

Date

Patient/Representative Signature

Relationship to Patient
(self, parent, spouse, legal guardian/representative, sibling,
healthcare power of attorney, guarantor, etc.)

OFFICE POLICIES

PHONE MESSAGES:

If you call before 3:30pm, we will make every effort to return your call the same day. Always provide your full name, date of birth, contact number, and reason for the call. You may also send your Physician a message via the Patient Portal.

PRESCRIPTION REFILLS:

Our office requests 48-72 hours turn-around time for all prescriptions and refills requests. Depending on your specific health conditions and/or medications, your Physician may need to see you every 3-6 months, prior to refilling your medications.

- Be sure to call your Pharmacy and they will send us a refill request electronically. If you do not have any refills left, then your Pharmacy will need to send us a refill request. Refills are only processed Monday-Friday.
 - For Controlled prescriptions please allow at least 72 business hours to process.

AUTHORIZATIONS:

Insurance companies may require authorization for testing and medication. It can take up to 14 days to get the authorization or denial.

FMLA/DISABILITY FORMS:

Please allow 7-10 business days for completion of these documents. You will be charged a fee of \$30.00 to complete any forms. You may be asked to schedule an appointment with your Physician to discuss.

NO SHOW/LATE POLICY:

Missed appointments prevent our ability to care for your health needs and the needs of other patients who could have been seen in the time set aside for you.

- If unable to keep your appointment, please give us 24 hours' notice.
- It is our office policy to dismiss patients from our practice for repeat failure to keep scheduled appointments; this normally means 3 missed appointments in a 12-month period.
- If you arrive to your scheduled appointment more than 15 minutes late, you will be asked to reschedule.

We appreciate your understanding and cooperation as we assist you in your healthcare needs.
Thank you for choosing Colorectal Surgical Associates.

PATIENTS NAME: _____ **DOB** _____

PATIENTS SIGNATURE: _____

DATE _____

CSA New Patient Intake Packet

Name: _____ DOB: _____

Please complete this form prior to your appointment. If you are unsure of an answer, leave it blank.

Social History

Tobacco / Nicotine Use

Do you currently use any tobacco or nicotine products? ☐ No ☐ Yes

If yes, which type(s)? (Check all that apply.)

- ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Chewing tobacco ☐ Snuff
☐ Vaping/E-cigarettes ☐ Other: _____

How often do you use them? ☐ Every day ☐ Some days ☐ Rarely

Are you interested in quitting? ☐ No ☐ Yes ☐ Not at this time

Have you used tobacco or nicotine products in the past? ☐ No ☐ Yes Year quit: _____

Alcohol Use

Do you currently drink alcohol? ☐ No ☐ Yes

If yes, how often do you drink alcohol? ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely

Do you have a history of alcohol dependence or alcohol use disorder? ☐ No ☐ Yes

Cannabis & Recreational Drug Use

Do you currently use cannabis (marijuana, THC, CBD) or recreational drugs? ☐ No ☐ Yes

If yes, which type(s)? (Check all that apply.)

- ☐ Marijuana (THC/Cannabis) ☐ Methamphetamine
☐ CBD only ☐ Cocaine
☐ Non-prescribed opioids ☐ Other: _____

Have you ever used recreational drugs or non-prescribed substances in the past? ☐ No ☐ Yes

Safety Screening

Do you currently feel safe in your home? ☐ No ☐ Yes

Have you ever experienced physical or sexual abuse that may affect your pelvic health or medical care?

☐ No ☐ Yes ☐ Prefer not to answer

Past Medical History

(check all that apply)

- | | | | |
|--|---|---|--|
| ☐ High blood pressure | ☐ Heart disease | ☐ Diabetes | ☐ Stroke |
| ☐ COPD/Asthma | ☐ Kidney disease | ☐ Liver disease | ☐ Thyroid disease |
| ☐ Crohn's disease | ☐ Ulcerative colitis | ☐ Colon polyps | ☐ Pelvic floor disorder |
| ☐ Colon cancer | ☐ Rectal cancer | ☐ Other cancer (type: _____) | |
| ☐ Bleeding disorder | ☐ Anxiety/Depression | ☐ None | |
| ☐ Other significant medical conditions: _____ | | | |

List previous surgeries and approximate year. Use the back of the page if more space is needed.

Colonoscopy History

If yes, most recent colonoscopy:

Results: _____ Repeat recommended in _____ years

If yes, approximate year: _____ Result: ☐ Negative ☐ Positive ☐ Unsure

History of a 3rd or 4th degree tear (involving the anal sphincter)? ☐ No ☐ Yes ☐ Unsure

Check all that apply. If none apply, leave table blank.

☐ Check box if family history is unknown[illegible]

Medications

Please list medications below or attach a medication list. Use the back of the page if more space is needed.

MEDICATION	DOSE / FREQUENCY	REASON FOR TAKING

Allergies

☐ No known drug allergies

MEDICATION / SUBSTANCE	REACTION

Current Symptoms (check all that apply)

Please check any symptoms you are currently experiencing:

General

- ☐ Fever
- ☐ Chills
- ☐ Fatigue
- ☐ Weight loss

GI

- ☐ Abdominal pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea/vomiting
- ☐ Bloating
- ☐ Change in bowel habits

Rectal/Anal

- ☐ Rectal bleeding
- ☐ Hemorrhoids
- ☐ Anal/rectal pain
- ☐ Anal itching
- ☐ Rectal prolapse
- ☐ Rectal drainage/mucus
- ☐ Stool leakage
- ☐ Difficulty emptying