GALLIANO SURGICAL GROUP

DATE: _____/_____/_____

LAST NAME: _____ FIRST NAME: _____ MI: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

SS#: _____ DOB: _____ AGE: _____ MALE: _____ FEMALE: _____

HOME PHONE: _____ CELL: _____ EMPLOYER: _____

EMAIL ADDRESS: _____

INSURANCE PLAN: _____ ID#: _____

SUBSCRIBER NAME: _____ SUBSCRIBER DOB: _____

PRIMARY CARE PHYSICIAN: _____

REFERRING PHYSICIAN: _____

PHARMACY: _____

PREFERRED LAB: _____

PREFERRED IMAGING FACILITY: _____

PLEASE INDICATE IF MESSAGES CAN BE LEFT: HOME PHONE ___YES ___ NO / CELL ___YES ___NO

PLEASE INDICATE IF TEXT MESSAGES CAN BE SENT: CELL ___YES ___ NO

****IMPORTANT NOTICE****

I FULLY UNDERSTAND THAT IT IS MY RESPONSIBILITY TO OBTAIN A REFERRAL/AUTHORIZATION FOR THIS VISIT IF IT IS REQUIRED BY MY INSURANCE COMPANY. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES REGARDLESS OF INSURANCE COVERAGE. I GIVE THIS OFFICE PERMISSION TO RELEASE ANY INFORMATION OBTAINED DURING EXAMINATION OR TREATMENTS OF THIS PATIENT THAT IS NECESSARY TO SUPPORT ANY INSURANCE CLAIMS ON THIS ACCOUNT AND SECURE TIMELY PAYMENT DUE TO ASSIGNEE OR MYSELF. I HEREBY ASSIGN MEDICAL BENEFITS, INCLUDING THOSE FROM GOVERNMENT SPONSORED PROGRAMS AND OTHER HEALTH PLANS TO BE PAID TO THE PARTY WHO ACCEPTS ASSIGNMENT. A PHOTOCOPY OF THIS ASSIGNMENT IS TO BE CONSIDERED AS GOOD AS THE ORIGINAL.

_____ DATE: _____

PATIENT SIGNATURE INDICATING AGREEMENT TO ALL THE ABOVE

PRINT NAME: _____

Tel. (941) 625-3411 – Fax (941) 625-1792 – www.GallianoSurgery.com
Murdock Circle Executive Center – 18308 Murdock Circle, Suite 108 – Port Charlotte, Florida 33948

GALLIANO SURGICAL GROUP

INSURANCE AND FINANCIAL POLICIES

WHEN YOU PRESENT FOR YOUR APPOINTMENT A VALID INSURANCE CARD SHOULD BE BROUGHT WITH YOU. IF PRE-APPROVAL OR PRIOR AUTHORIZATION IS NECESSARY FOR PAYMENT WE EXPECT YOU TO OBTAIN THAT FROM YOUR PRIMARY CARE PHYSICIAN. IF YOU ARE UNDER A MEDICARE HMO YOU ARE NO LONGER UNDER MEDICARE FOR YOUR PHYSICIAN PAYMENT. PLEASE NOTIFY US IMMEDIATELY IF ANY CHANGES OCCUR TO YOUR INSURANCE COVERAGE. WE WILL FILE TO A SECONDARY INSURANCE, FOR YOUR REIMBURSEMENT, ONLY ONCE FOR EACH CLAIM. YOU ARE ULTIMATELY RESPONSIBLE FOR THE BILLING BUT WE WILL FILE THE INSURANCE AS A COURTESY TO YOU. AFTER THREE MONTHS YOU WILL BE RESPONSIBLE TO COMMUNICATE WITH YOUR INSURANCE COMPANY FOR PAYMENT. WE WILL NO LONGER COMMUNICATE WITH THE INSURANCE COMPANY AFTER THAT TIME.

ALL SELF PAY PATIENTS ARE EXPECTED TO PAY IN FULL AT THE TIME OF SERVICE. IF A PROCEFURE IS SCHEDULED PAYMENT WILL BE COLLECTED AT THE TIME OF SCHEDULING.

IF A SURGICAL PROCEDURE IS SCHEDULED WE WILL PRE-CERTIFY WITH YOUR INSURANCE COMPANY. HOWEVER, THAT IS NOT A GUARANTEE OF PAYMENT AND AGAIN YOU THE PATIENT IS RESPONSIBLE TO MAKE SURE THIS BILL IS PAID.

PLEASE NOTE! MANY TIMES YOUR INSURANCE COMPANY DOES NOT RESPOND PROMPTLY. IT IS A GOOD IDEA TO CHECK PERIODICALLY TO MAKE SURE YOUR INSURANCE CLAIMS ARE GETTING PAID.

PLEASE READ AND SIGN BELOW:

PATIENT SIGNATURE: _____ DATE: _____

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GALLIANO SURGICAL GROUP

Acknowledgement of Receipt of Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

You may refuse to sign this acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Patient Name (Printed)

_____
Signature

_____
Date

Authorization to Release Information

Purpose: This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself.

I, _____, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

_____ _____
Name (printed) Relationship

_____ _____
Name (printed) Relationship

_____ _____
Name (printed) Relationship

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign

__ Communications barriers prohibited obtaining the acknowledgement

__ An emergency situation prevented us from obtaining acknowledgement

__ Other (please specify) _____

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GALLIANO SURGICAL GROUP
HEALTH INFORMATION FORM

Todays Date: _____ DOB: _____

LAST NAME: _____ FIRST NAME: _____

*Do you have an Advanced Directive or Living Will: YES or NO

Reason for Todays Visit: _____

Location of problem: _____

On a scale of 1-10, 10 as most severe, rate your problem: 1 2 3 4 5 6 7 8 9 10

When did you notice the problem: _____

Does anything HELP or make the problem WORSE: Sitting Standing Running Etc.

_____

Are there any other issues occurring at the same time: _____

_____

Is your problem CONSTANT or VARIABLE? Circle One

Does the problem interfere with normal activities? Yes or No If yes, please explain:

_____

How long does the problem last? _____

Past Surgeries &/or Illnesses including dates: _____

_____

_____

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: _____

_____

_____

_____

LIST ALL ALLERGIES: _____

_____

LIST ILLNESS IN YOUR IMMEDIATE FAMILY: (DIABETES, CANCER, HEART DISEASE, ETC.) & INCLUDE RELATIONSHIP: _____

_____

_____

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Patient Name:_____

REVIEW OF SYMPTOMS Do you currently, or have you had a problem with:

Constitutional	Yes	No
Fever	☐	☐
Weight loss	☐	☐
Weakness	☐	☐
Fatigue	☐	☐

Eyes	Yes	No
Blurred vision	☐	☐
Uses glasses/contacts	☐	☐
Cataracts	☐	☐
Redness	☐	☐
Infection	☐	☐

Ears, Nose, Mouth, Throat	Yes	No
Hearing loss	☐	☐
Ringing in ears	☐	☐
Dizziness	☐	☐
Nose bleeds	☐	☐
Nasal congestion	☐	☐
Sinus problems	☐	☐
Difficulty swallowing	☐	☐
Hoarseness	☐	☐

Cardiovascular	Yes	No
Chest pain	☐	☐
Palpitations	☐	☐
Edema	☐	☐
Cool extremities	☐	☐
Leg pain while walking	☐	☐

Respiratory	Yes	No
Wheezing	☐	☐
Cough	☐	☐
Shortness of breath	☐	☐
Bloody mucous	☐	☐

Psychiatry	Yes	No
Anxiety	☐	☐
Depression	☐	☐

Integumentary	Yes	No
Rashes	☐	☐
Lesions	☐	☐
Lumps	☐	☐
Hair loss	☐	☐

Endocrine	Yes	No
Heat/cold intolerance	☐	☐
Increased thirst	☐	☐
Night sweats	☐	☐
Hot flashes	☐	☐

Gastrointestinal	Yes	No
Poor appetite	☐	☐
Nausea	☐	☐
Vomiting	☐	☐
Rectal bleeding	☐	☐
Change in bowel habits	☐	☐
Diarrhea	☐	☐
Constipation	☐	☐
Indigestion	☐	☐
Hemorrhoids	☐	☐
Yellowing of skin/eyes	☐	☐
Abdominal pain	☐	☐

Genitourinary	Yes	No
Frequency	☐	☐
Urgency	☐	☐
Painful urination	☐	☐
Blood in urine	☐	☐
Incontinence	☐	☐
Urinary infections	☐	☐

Musculoskeletal	Yes	No
Joint pain	☐	☐
Joint stiffness	☐	☐
Backache	☐	☐
Muscle pain/cramps	☐	☐
Swelling joints	☐	☐
Difficulty walking	☐	☐

Neurological	Yes	No
Fainting	☐	☐
Blackouts	☐	☐
Numbness or tingling	☐	☐
Loss of sensation	☐	☐
Paralysis	☐	☐
Tremors	☐	☐
Memory loss	☐	☐
Balance issues	☐	☐
Headaches	☐	☐
Weakness	☐	☐

Hematological/Lymphatic	Yes	No
Easy bruising	☐	☐
Swollen glands	☐	☐
Bleeding problems	☐	☐

Allergic/Immunologic	Yes	No
Seasonal allergies	☐	☐
Food/medication allergies	☐	☐

Provider Signature:_____ Date:_____

GALLIANO SURGICAL GROUP

Current/Past Medical History

TODAYS DATE:_____/_____/_____ FIRST NAME:_____

DOB: _____/_____/_____ LAST NAME:_____

Abdominal Aorta Aneurysm	YES / NO	Hemorrhoids	YES / NO
Alcoholism	YES / NO	Hepatitis/If yes, what type:	YES / NO
Anemia	YES / NO	Hernia/If yes, please specify:	YES / NO
Anxiety	YES / NO	High Cholesterol	YES / NO
Arthritis	YES / NO	HIV	YES / NO
Asthma	YES / NO	Hypertension	YES / NO
Atrial Fibrillation	YES / NO	Hyper/Hypo thyroidism	YES / NO
Autoimmune Disorder If yes, please specify:	YES / NO	Irritable Bowel Syndrome	YES / NO
Bleeding Disorder If yes, please specify:	YES / NO	Kidney Disease	YES / NO
Cancer If yes, please specify:	YES / NO	Kidney Stones	YES / NO
C-DIFF	YES / NO	Liver Disease	YES / NO
Cirrhosis	YES / NO	Morbid Obesity/Obesity	YES / NO
Colon Polyps	YES / NO	MRSA	YES / NO
Constipation	YES / NO	Osteoporosis/Osteopenia	YES / NO
COPD	YES / NO	Pancreatitis	YES / NO
Cardiovascular Disease If yes, please specify:	YES / NO	Peptic Ulcer Disease	YES / NO
Deep Vein Thrombosis	YES / NO	Pulmonary Embolism	YES / NO
Depression	YES / NO	PTSD	YES / NO
Diabetes	YES / NO	Rectal bleeding	YES / NO
Diarrhea	YES / NO	Rheumatoid Arthritis	YES / NO
Diverticular Disease If yes, please specify:	YES / NO	Seizures/Epilepsy	YES / NO
Fecal Incontinence	YES / NO	STD	YES / NO
Gall Stones	YES / NO	Sleep Apnea	YES / NO
GERD/Acid Reflux	YES / NO	Stroke	YES / NO
Gout	YES / NO	Tuberculosis	YES / NO
Headaches	YES / NO	Other:	YES / NO

Bowel Symptom Questionnaire

Name: _____ Date: _____

Doctor: _____

Which symptoms best describe you? Check all that apply.

- ☐ Accidental loss or leakage of stool—sometimes unable to make it to the bathroom in time
- ☐ Bowel accidents while unaware—no warning and/or while asleep
- ☐ Frequent, loose, watery stools
- ☐ Sudden or strong urge to go to the bathroom
- ☐ Bowel accidents when passing gas
- ☐ No bowel problems (if checked, please discontinue questionnaire)

How long have you had these symptoms? _____

Approximately how many bowel incidents do you have per week? _____

Have you tried medications to help your symptoms? ☐ Yes ☐ No

On a scale of 0 to 10, with 0 being no symptom relief and 10 being complete symptom relief, how much symptom relief have these medications provided for you? Circle number.

0	1	2	3	4	5	6	7	8	9	10

No Relief *Complete Symptom Relief*

Behavior modifications tried? _____
(e.g., lifestyle changes, fiber, diet changes, physical therapy)

On a scale of 0 to 10, with 0 being no frustration at all and 10 being extremely frustrated, what is your level of frustration with your bowel control symptoms? Circle a number.

0	1	2	3	4	5	6	7	8	9	10

Not Frustrated *Very Frustrated*

Are you interested in learning more about additional treatment alternatives to bowel medications?

☐ Yes ☐ No

UC201201780b EN

PATIENT PRE-SCREENING QUESTIONNAIRE

***Due to the ongoing COVID-19 Pandemic, ALL patients are required to complete this form prior to being seen at Galliano Surgical Group practice. Your visit is subject to approval upon completion of this form. Effective immediately, only the patient is allowed in the practice. Patients needing assistance must inform the front desk staff. These rules are being enforced to keep our patients and staff safe and healthy.**

1. Have you or Anyone in your household had any of the following symptoms in the last 14 days:
SORE THROAT, COUGH, CHILLS, BODY ACHES FOR UNKNOWN REASONS, SHORTNESS BREATH FOR UNKNOWN REASONS, LOSS OF SMELL, NAUSEA, VOMITING, DIARRHEA, LOSS OF TASTE, FEVER AT OR GREATER THAN 100 DEGREES FAHRENHEIT?

YES ☐ NO ☐

2. Have you or anyone in your household been tested for COVID-19?

YES ☐ NO ☐

*If so, what were your results?

NEGATIVE ☐ POSITIVE ☐

3. Have you or anyone in your household cared for an individual who is in quarantine or is a presumptive positive or has tested positive for COVID-19 in the last 14 days?

YES ☐ NO ☐

4. To the best of your knowledge have you been in close proximity to any individual who tested positive for COVID-19?

YES ☐ NO ☐

5. Have you or anyone in your household traveled in the U.S. or outside of the U.S. in the past 14 days?

YES ☐ NO ☐

Please return this form to the front desk when completed.
By signing below, you certify that the answers above are true and correct.

Patient Signature: _____ Date: _____

Print Name: _____