Guy R. Winzenried MD FACG

PATIENT NAME: First _____ **M:** _____ **Last** _____

DATE OF BIRTH: _____ **GENDER: (CIRCLE ONE)** **Male** **Female**

ADDRESS: _____ **UNIT** _____

CITY/STATE/ZIP _____

HOME PHONE # _____ **CELL #** _____

EMAIL _____

RACE (CIRCLE ONE) **WHITE** **AFRICAN AMERICAN** **ASIAN** **AMERICAN INDIAN** **UNKN**

ETHNICITY (CIRCLE ONE) **HISPANIC/LATINO /** **NOT HISPANIC/ LATINO /** **PATIENT DECLINES TO SPECIFY /** **PROHIBITED BY LAW**

SOCIAL SECURITY # _____

LOCAL PRIMARY PHYSICIAN _____ **REFERRING PHY** _____

MARITAL STATUS (circle one): **Single** **Married** **Divorced** **Widowed**

EMERGENCY CONTACT NAME: _____

RELATIONSHIP TO PATIENT: _____ **Phone** _____

(circle one) Home Cell Work

PHARMACY _____ **PHONE#** _____

DRUG ALLERGIES _____

PRIMARY POLICY HOLDER _____

DATE OF BIRTH _____ **SOCIAL SECURITY #** _____

NORTHERN ADDRESS INFORMATION

STREET ADDRESS _____ UNIT _____ CITY/STATE/ZIP _____

PHONE # (include Area Code): _____

By signing below, I acknowledge the following:

I hereby authorize the provider to treat me.

I hereby attest that the personal and financial information given above is true and that my personal identification or insurance information has not been falsified.

A parent or guardian responsible for payment of the bill is accompanying the child at the time of service unless a separate permission form has been signed. Guy R. Winzenried MD cannot be bound by any divorce or other family relationship contracts.

I hereby authorize insurance benefits including Medicare benefits, to be paid directly to the physician providing services and recognize it is my responsibility to pay for all non-covered services. I also, authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid (CMS) and it's agents or any other third party liability or insurance carrier, any information needed to determine these benefits or the benefits payable for related services.

I have reviewed and understand all of the second page of this document, including the HIPAA.

Notice of Privacy Practice Statement, as indicated with my signature and date below.

SIGNATURE: _____ DATE: _____

WELCOME TO THE PRACTICE OF GUY R. WINZENRIED MD FACG LLC

We believe it is important for our patients to fully understand our Financial Policy and acknowledge that they have read our Notice of Privacy Practices. Please review the Financial Policy below and the Notice of Privacy Practices document carefully. To avoid any misunderstanding regarding this policy, it is necessary for you to read both and sign on the first page of this document, before treatment is rendered. Please ask us any questions you may have regarding this document and take a copy of both policies home for future reference if necessary.

OUR FINANCIAL POLICY

This policy covers consults, office visits, any testing ordered by Dr Winzenried. By signing on the bottom of first page of this document, I am agreeing to the terms of this Financial Policy.

Medicare Patients: We are participating physicians with Medicare. This means that you will be responsible for the 20% of the approved Medicare fee for covered services, the current yearly deductible and full payment of the of any non-covered. Non-Covered services include, but are not limited to, annual physical exams. diagnostic tests performed for screening purposes.

Payment is due at time of service: Payment is due in full at the time of service unless you are covered by Medicare or an insurance company with which we participate (please see insurance information below). You will be charged a $35 service fee for any returned checks, no exceptions.

Insurance: Patients will be asked to present their insurance card to the receptionist for copying upon check-in at the office **each time** they are seen for medical services. Please make it a point to bring your insurance cards with you **each time** you visit our office. Claims not paid within 45 days by your insurance company will become your responsibility. You will receive a statement for these services and you will need to contact your insurance company for reimbursement.

For those patients covered by insurance plans with which we **ARE** participating providers, all co-payment, deductibles and non-covered services are due at the time of service. We will file a claim to the insurance company on your behalf. In the event that you are covered by (or your coverage changes to) a plan with which we **ARE NOT** participating providers, we may require payment in full at the time of service. And charges that are not paid by your insurance are your responsibility. Your insurance policy is a contract between YOU and your insurance company. **Any pre-certification of procedures or testing are your responsibility. Please let us know in advance if your insurance company requires this.**

Surcharge for Missed Appointments: Patients may be subject to a surcharge for missed appointments if cancellation is not received at least 24 hour before the time of the appointment. Check with your provider regarding their policy. More than three missed appointments without the required notice result in termination from the practice.

ACKNOWLEGEMENT OF NOTICE OF PRIVACY PRACTICES STATEMENT

I have been given the opportunity to review the policy Guy R. Winzenried MD., FACG Notice of Privacy Practices prior to signing this acknowledgement. Guy R Winzenried MD reserves the right to review its Notice of Privacy Practices at any time.

By signing on the first page of this document, I hereby acknowledge that I have been notified of the following:

- Guy R. Winzenried MD utilizes an electronic medical records system and this allows access to your prescription history, drug benefit coverage and enables new prescriptions to be electronically routed to the pharmacy of your choice

- Guy R. Winzenried MD participates in a Health Information Exchange (HIE) which is an organization that allows health care providers in different places to access information about you so that each provider has a complete picture of your health. HIEs can also avoid the need for you to undergo duplicate test, because health care providers will have access to results of tests conducted elsewhere. The information that may be provided to an HIE includes both medical and demographic information about you . Your health information will be made accessible to health care providers who participate in the HIE unless you "opt out" by notifying the registration clerk now.

- Guy R Winzenried MD may use and disclose my protected health information to carry out treatment, payment and healthcare operations. Guy R. Winzenried MD Notice of Privacy Practices provides a complete description of such uses and disclosures. Uses and disclosures not listed in the Notice of Privacy Practices will require my prior written authorization. Guy R. Winzenried MD is authorized to use my personal information to secure payment for services rendered and will comply with all reasonable measure to follow the FTC guidelines regarding identify theft I understand that I can require that medical information not be disclosed to a health plan if I pay for those services out of pocket. I may make restrictions to the use and disclosure of my protected health information or revoke a previous request for restriction at the time except to the extent that the practice has already made disclosures in reliance upon my prior authorization to do so. Both Requests for Restriction and Revocations must be in writing. By signing on the first page of this document I am acknowledging that I have received Guy R. Winzenried MD Notice of privacy Practices and understand my rights to modify how my information is used and disclosed. If Dr. Winzenried MD determines that my restrictions make it impossible for them to carry out my treatment, payment and healthcare operations, they may refuse to accept me as a patient.

Guy Winzenried MD, FACG

Bigham Galleria: 2425 Tamiami Tr North, Suite 210 Naples, FL 34103

Ph. (239) 228-6283 ~ Fax (239) 228-6293

Diplomate American Board of Internal Medicine, Gastroenterology and Hepatology

Patient Interview Form

Patient Information

First Name:_____ Last Name:_____

Date Of Birth:_____ Age:_____

Sex

◯ Male ◯ Female ◯ Other

Allergies

◯ Patient has no known allergies ◯ Patient has no known drug allergies

◯ Codeine Sulfate ◯ Penicillins ◯ Anesthesia ◯ Sulfa (Sulfonamide Antibiotics) ◯ aspirin (bulk)

Other:_____

Current Medications

◯ None

Name Dose

_____

_____

_____

Social History

Occupation:_____ Number of Children:_____

Marital Status

◯ Single ◯ Married ◯ Divorced ◯ Separated ◯ Widowed

Alcohol

◯ None

Type Quantity Number Frequency

_____

Tobacco

Smoking Status

- ◯ Current every day smoker
- ◯ Current some day smoker
- ◯ Former smoker
- ◯ Never smoker
- ◯ Smoker, current status unknown
- ◯ Light tobacco smoker
- ◯ Heavy tobacco smoker
- ◯ Unknown if ever smoked

Drug Use

- ◯ None
- ◯ Narcotics

Exercise

- ◯ None
- ◯ I walk
- ◯ I jog
- ◯ I Bike
- ◯ I Golf
- ◯ Tennis
- ◯ Lift Weights
- ◯ Swim
- ◯ Yoga

Past or Present Medical Conditions

- ◯ None
- ◯ Anemia
- ◯ Cirrhosis
- ◯ Colitis
- ◯ Colon cancer
- ◯ Colon polyps
- ◯ Crohn's Disease
- ◯ Pancreatitis
- ◯ Diabetes Mellitus
- ◯ Diverticulitis
- ◯ Diverticulosis
- ◯ Duodenal Ulcer
- ◯ Fatty Liver
- ◯ Gallstones
- ◯ Hepatitis
- ◯ Hepatitis B
- ◯ Hepatitis C
- ◯ Hiatal hernia
- ◯ IBS
- ◯ Lactose Intolerance
- ◯ Glaucoma
- ◯ Stomach Ulcer
- ◯ Ulcerative Colitis
- ◯ Asthma
- ◯ Atrial Fibrillation
- ◯ Back Pain (chronic)
- ◯ Breast cancer
- ◯ Skin Cancer
- ◯ Congestive Heart Failure
- ◯ Depression
- ◯ Stroke
- ◯ Heart Attack
- ◯ Heart Murmurs
- ◯ High blood pressure
- ◯ High Cholesterol
- ◯ High Triglycerides
- ◯ Irregular Heart Beat
- ◯ Chronic Kidney Disease
- ◯ TB exposure
- ◯ Migraines
- ◯ Osteoarthritis
- ◯ Seizures
- ◯ Sleep apnea
- ◯ Thyroid disorder
- ◯ Uterine Cancer
- ◯ Prostate Cancer
- ◯ HIV
- ◯ Ischemic heart disease
- ◯ Other _____
- ◯ C.O.P.D.
- ◯ Coronary artery disease

Previous Procedures

- ◯ None
- ◯ Colonoscopy
- ◯ EGD
- ◯ C-Section
- ◯ Cardiac Surgery
- ◯ Joint Surgery
- ◯ Gallbladder removed
- ◯ Thyroidectomy
- ◯ Tonsillectomy
- ◯ Pacemaker
- ◯ Nephrectomy
- ◯ Gastric By-Pass
- ◯ Gastric Band
- ◯ Breast Augmenation
- ◯ Liver Biopsy
- ◯ Hemorrhoidectomy
- ◯ Coronary artery bypass surgery
- ◯ Hysterectomy
- ◯ Prostatectomy
- ◯ Appendectomy

Immunizations

- ◯ None
- ◯ Hep A, adult
- ◯ Hep B, adult
- ◯ Influenza, seasonal, injectable
- ◯ Pneumonia

Family Medical History

○ No knowledge of family history

No family history of ○ Colon cancer ○ Polyps

Diagnoses	Mother	Father	Sister	Brother	Daughter	Son	Grandmother	Grandfather
Colon Cancer - Age diagnosed____	○	○	○	○	○	○	○	○
Colon Polyps	○	○	○	○	○	○	○	○
Ulcerative colitis, unspecified	○	○	○	○	○	○	○	○
Crohn's Disease	○	○	○	○	○	○	○	○
Family History of Diabetes	○	○	○	○	○	○	○	○
Impaired gallbladder function	○	○	○	○	○	○	○	○
Family History of Heart Trouble	○	○	○	○	○	○	○	○
Liver Cancer/Disease	○	○	○	○	○	○	○	○
Ulcer Disease	○	○	○	○	○	○	○	○
Irritable bowel syndrome	○	○	○	○	○	○	○	○
prostate cancer	○	○	○	○	○	○	○	○
breast cancer	○	○	○	○	○	○	○	○
Pancreas Cancer	○	○	○	○	○	○	○	○
Lung Cancer	○	○	○	○	○	○	○	○
Cervical/Ovarian Cancer	○	○	○	○	○	○	○	○

MARK YES ONLY

Review Of Systems

Allergic/Immunologic

○ None	Y	N
HIV exposure	○	○
persistent infections	○	○
strong allergic reactions or urticaria	○	○

Cardiovascular

○ None	Y	N
chest pain	○	○
dyspnea with exercise	○	○
irregular heart beat	○	○
orthopnea	○	○
palpitations	○	○
peripheral edema	○	○
syncope	○	○

Constitutional

○ None	Y	N
fatigue	○	○
fever	○	○
loss of appetite	○	○
malaise	○	○
sweats	○	○
weight gain	○	○
weight loss	○	○

ENMT

○ None	Y	N
difficulty swallowing	○	○
dizziness	○	○
ear pain	○	○
nasal obstruction	○	○
nose bleeds	○	○
sore throat	○	○
hearing loss	○	○

Endocrine

○ None	Y	N
excessive thirst	○	○
hair loss	○	○
heat intolerance	○	○

Eyes

○ None	Y	N
double vision	○	○
loss of vision	○	○
photophobia	○	○

Genitourinary

○ None	Y	N
dark urine	○	○
decrease in urine flow	○	○
dysuria	○	○
frequent urinary infections	○	○
frequent urination	○	○
hematuria	○	○
impotence	○	○
nocturia	○	○
urethral discharge or incontinence	○	○

Gastrointestinal

○ None	Y	N
abdominal swelling	○	○
change in bowel habits	○	○
constipation	○	○
diarrhea	○	○
gas	○	○
heartburn	○	○
jaundice	○	○
nausea	○	○
rectal bleeding	○	○
stomach cramps	○	○
vomiting	○	○
difficulty swallowing	○	○
dyspepsia	○	○
abdominal pain upper	○	○
abdominal pain lower	○	○
anal/rectal pain	○	○
belching	○	○
black stools	○	○
bloating	○	○
dairy intolerance	○	○
hemorrhoids	○	○
mucus in stool	○	○
pain with bowel movement	○	○
rectal urgency	○	○
reflux	○	○
soiling stool/incontinence	○	○
weight loss less than 10 lbs	○	○
weight loss more than 10 lbs	○	○
weight gain more than 10 lbs	○	○
weight gain less than 10 lbs	○	○

Hematologic/Lymphatic

○ None	Y	N
bleeding gums or palpable lymph nodes	○	○
easy bruising	○	○
prolonged bleeding	○	○

Integumentary

○ None	Y	N
allergies	○	○
dryness	○	○
hives	○	○
itching	○	○
jaundice	○	○
lesions	○	○
rashes	○	○

Musculoskeletal

○ None	Y	N
arthritis	○	○
back pain	○	○
gout	○	○
joint deformity	○	○
joint pain	○	○
muscle weakness	○	○
stiffness	○	○

Neurological

○ None	Y	N
dizziness	○	○
fainting	○	○
frequent headaches	○	○
migraine	○	○
numbness or tingling	○	○
seizures	○	○
tremors	○	○
vertigo	○	○
memory loss	○	○

Psychiatric

○ None	Y	N
anxiety	○	○
depression	○	○
difficulty sleeping	○	○
hallucinations	○	○
nervousness	○	○
panic attacks	○	○
paranoia	○	○

Respiratory

○ None	Y	N
asthma	○	○
cough	○	○
dyspnea	○	○
excessive sputum	○	○
coughing up blood	○	○
shortness of breath with exercise	○	○
wheezing	○	○

Consent to Import Medication History

I consent to obtaining a history of my medications purchased at pharmacies.

○ Yes ○ No

GUY WINZENRIED MD
BIGHAM GALLERIA
2425 Tamiami Trail., Suite 210
Naples, Florida 34104
(239) 228-6283
(239) 228-6293 fax

HEALTH INFORMATION MANAGEMENT

PATIENT REQUEST FOR MEDICAL RECORDS

Specifically describe the records to be released: (i.e. dates of service or study type)

_____

_____

Please Check One:

I would like my records mailed to my home at :

_____

_____

_____ I would like to pick up my records at

_____Contact me at the following phone number when records are ready_____

_____I would like my records faxed to my home fax number :_____

I understand that the first copy of my medical records will be available at no charge. Copies after the initial set will be charged to me to cover copying charges, including the cost of supplies and labor, and postage related to the production of my information. I understand that the charge for this service is $1.00 per page, up to 25 pages and $ 0.25 per page thereafter. Payment is due prior to release. I understand that record requests are processed in the order in which they are received. I understand that record requests are processed in the order in which they are received. I understand that it may take from 7 to 10 business days to make the copies, depending on the amount of records to be copied.

_____ _____

Signature of Patient or Legal Guardian **Patient's Date of Birth**

_____ _____

Print Name of Patient or Legal Guardian **Relationship to the Patient**