David H. Gibbs, M.D.
Virginia B. Winburn, M.D.
Kerry L. Hammond, M.D.

Colon and Rectal Surgery Associates, P.C.

Diplomates
American Board of Surgery
American Board of
Colon and Rectal Surgery

We want to make your experience with Colon and Rectal Surgery Associates as pleasant as possible. The enclosed patient information sheet needs to be completed and returned the day of your appointment. All questions on the sheet need to be answered to enable the physician to assess your medical condition for treatment.

- All patients referred for consultation, even those referred for colonoscopy, will be given a thorough History & Physical Exam. A rectal examination may be part of your initial office exam.
- It is very important that you bring **all** the medications you are currently taking to your appointment.
- Please refrain from wearing perfume or cologne to the office.
- We require your insurance card and a photo identification at the time of your visit.
- We participate with most major insurance companies including Medicaid but not all. It is your responsibility to check to see if Colon Rectal Surgery Associates is in network with your insurance.
- **We expect your co-pay or co-insurance (the portion not covered by your insurance company) at the time of your visit.**
- **We accept cash, check, MasterCard, VISA, Discover and Care Credit.** If you do not have medical insurance, a **$311.90** cash or credit card deposit is required at check-in prior to seeing the physician. If you do not have your co-pay or deposit at the time of your appointment, we will be glad to reschedule your appointment.

If you are coming to discuss having a procedure done, e.g., colonoscopy, you may be asked to pay a deposit for the procedure if your insurance **does not cover it.** The deposit **must be paid 72 business hours** prior to the day of the procedure. This amount is determined by the type of insurance coverage you have. **It is your responsibility to know whether you have coverage for colon screening or does the procedure need to be for diagnostic reasons. Please advise our office staff in regards to this matter to accurately bill for your procedure. If you do not know, please call your insurance company prior to your appointment.**

There are times when our physician is called to the hospital for emergency treatment. Should this occur, your appointment time may need to be changed. We will make every effort to work with you regarding this situation.

We want to thank you for placing your confidence with our physicians and look forward to seeing you.

Sincerely,
COLON & RECTAL SURGERY ASSOCIATION

410 University Parkway, Suite 2100 • Aiken, South Carolina 29801 • (803) 648-1171 • Fax (803) 648-1666 • AikenColonAndRectalSurgery.com

COLON-RECTAL SURGERY ASSOCIATES, PC
DAVID H. GIBBS MD VIRGINIA B. WINBURN MD KERRY L. HAMMOND MD

PATIENT QUESTIONNAIRE

LEGAL LAST NAME _____

LEGAL FIRST NAME _____

FIRST NAME USED _____

MIDDLE NAME _____ SUFFIX _____

PREVIOUS NAME (First, Last) _____

LANGUAGE _____

RACE _____ ETHNICITY _____

MARITAL STATUS _____

LEGAL SEX ☐ MALE ☐ FEMALE

SEXUAL ORIENTATION:

- ☐ Lesbian, gay or homosexual
- ☐ Straight or heterosexual
- ☐ Bisexual
- ☐ Something else, please describe _____
- ☐ Don't know
- ☐ Choose not to discuss

GENDER IDENTITY

- ☐ Identifies as Male
- ☐ Identifies as Female
- ☐ Transgender Male/ Female to Male
- ☐ Transgender Female/Female to Male
- ☐ Gender not conforming Neither Male or Female
- ☐ Additional Gender Category/ Other Please Specify
- ☐ Choose not to discuss

ASSIGNED SEX AT BIRTH

- ☐ Male
- ☐ Female
- ☐ Choose not to discuss
- ☐ Unknown

HOMEBOUND? _____

DOB _____

SSN _____

ADDRESS _____

ADDRESS LINE 2 _____

ZIP _____

CITY _____

STATE _____

EMAIL _____

HOME PHONE _____

SAME AS MOBILE? ☐ YES ☐ NO

MOBILE PHONE _____

CONSENT TO CALL? ☐ YES ☐ NO

HOW SHOULD WE CONTACT YOU? _____

HOW DID YOU HEAR ABOUT US? _____

_____

GUARDIAN NAME _____

EMERGENCY CONTACT NAME _____

EMERGENCY CONTACT RELATION _____

EMERGENCY CONTACT PHONE _____

EMERGENCY CONTACT MOBILE _____

NEXT OF KIN NAME _____

NEXT OF KIN RELATION _____

NEXT OF KIN PHONE _____

PATIENT EMPLOYER _____

EMPLOYER PHONE _____

OCCUPATION _____

INS SUBSCRIBER NAME (primary person on insurance)

_____

RELATIONSHIP TO YOU _____

SUBSCRIBER DOB _____

PHARMACY _____

PHARMACY LOCATION _____

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PATIENT QUESTIONNAIRE

LIST THE PROBLEMS TO DISCUSS WITH YOUR DOCTOR (ROUTINE CHECK-UP/NO SYMPTOMS)

_____

_____

PLEASE LIST OTHER DOCTORS (e.g. SURGEONS, FAMILY PHYSICIAN, ETC.)

_____

_____

I authorize the electronic exchange of my health records to other providers for treatment purposes. Yes / No

I hereby authorize COLON-RECTAL SURGERY ASSOCIATES, PC (the practice) to release my medical information to all insurance carriers. I also authorize the practice to file all claims to my insurance carriers and payment to be made directly to the physician. I understand that I am responsible for any amount due by agreement with my insurance company. Should my account be turned over to the Collection Agency, I will be responsible for fees associated with collecting patient balance due.

_____ _____

Patient/Guardian Signature Date

I have received a copy of the HIPAA Notice of Privacy Practices. Initials: _____

I authorize the practice to retrieve my Medication History from my pharmacy Initials: _____

Designated Party Release

COLON-RECTAL SURGERY ASSOCIATES, PC
410 UNIVERSITY PARKWAY SUITE 2100
AIKEN, SC 29801
803-648-1171

Colon-Rectal Surgery Associates PC has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy. I have received and understand that I have the right to read the "Notice" before signing this agreement.

Colon- Rectal Surgery Associates, PC may update the "Notice of Privacy Practices". If I ask, Colon- Rectal Surgery Associates, PC will provide me with the most current "Notice of Privacy Practices".

You may give **Colon-Rectal Surgery Associates, PC** written authorization to disclose your protected health information to anyone that you designate, such as a family member or personal representative. If you wish to authorize a person to receive your protected health information, please complete the form below. You may also use this form to give us consent to leave detailed information (results of labs, x-ray, prescription refills, etc.) on your home answering machine, voice mail at work, cell phone, e-mail, or another party that you designate.

Patient Name: _____ Date of Birth: ___/___/_____

Date: ___/___/_____ Account #: _____ Chart #: _____

At my request, I authorize **Colon-Rectal Surgery Associates, PC** to disclose my protected health information to:

Name: _____ Phone #: _____

Name: _____ Phone #: _____

Name: _____ Phone #: _____

At my request, I also authorize **Colon-Rectal Surgery Associates, PC** to communicate my protected health information to me via the following methods:

☐ Leave detailed message on my home answering machine (phone #: _____)

☐ Leave detailed message on my voice mail at work (phone #: _____)

☐ Leave detailed message on my cell phone by text or voice mail (phone #: _____)

☐ Fax detailed medical information (fax #: _____)

☐ E-mail detailed medical information (e-mail: _____)

Authorized Signature: _____ Date: _____

I understand that I may cancel this authorization at any time by signing this notice below. However, if I cancel this authorization, I also understand that the cancellation will **not** affect any action **Colon-Rectal Surgery Associates, PC** took in reliance on this authorization before receipt of written notice of cancellation.

Signature Authorizing Cancellation: _____

Date Authorization Cancelled: ___/___/_____

COLON-RECTAL SURGERY ASSOCIATES, PC
410 UNIVERSITY PARKWAY SUITE 2100
AIKEN, SC 29801 (803) 648-1171

Patient Name: _____

PAST MEDICAL HISTORY: Please circle any of the following:

Anemia
Anxiety
Arthritis
Atrial Fibrillation
Bleeding Disorder
Bleeding or Bruising Problems
Bronchitis
COPD
Cancer
Colon Cancer
Colon Polyps
Rectal Cancer
Reflux/GERD
Tuberculosis

Coronary Artery Disease
Deep Vein Thrombosis
Dementia
Depression
Diabetes
Diverticulitis
Diverticulosis
Gout
Headache/Migraines
Heart Disease
Heart Failure
Seizures
Stroke

Hepatitis
High Cholesterol
Hypertension
Hyperthyroidism
Hypothyroidism
Irritable Bowel Syndrome
Kidney Disease/ Stones
Liver/Lung Disease
Peptic Ulcer
Prostate Enlargement (males)
Pulmonary Embolism
Sleep Apnea
Thyroid Disease

SURGERIES: Have you Ever Had: YEAR

Appendix:	yes	no	_____
Breast:	yes	no	_____
Colonoscopy:	yes	no	_____
Colon Surgery:	yes	no	_____
Gallbladder:	yes	no	_____
Heart:	yes	no	_____
Hernia:	yes	no	_____
Prostate:	yes	no	_____
Stomach:	yes	no	_____
Thyroid:	yes	no	_____
Upper endoscopy:	yes	no	_____

Other: _____

FAMILY HISTORY:

RELATION:	**PROBLEM:**	**AGE:**

Social History:
Smoke: Yes No
Alcohol: Yes No

ALLERGIES:

_____
_____
_____

MEDICATIONS:

Any additional medications, please use back side of page.

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PATIENT ACCOUNT NUMBER _____

EFFECTIVE JANUARY 1, 2023: IN AN EFFORT TO COMPLY WITH THE NO SURPRISE BILLING ACT WE MUST NOTIFY EACH PATIENT THAT WE WILL CHARGE FOR THE FOLLOWING AND IT WILL NOT BE BILLED TO YOUR INSURANCE COMPANY.

NO SHOW OFFICE VISIT (must cancel within 1 business day before office visit)	**$25.00**
NO SHOW PROCEDURE (must cancel 5 business days Prior to procedure)	**$50.00**
PHYSCIAN CALL TO PATIENT 1- 15 MINUTES	**$15.00**
PHYSICIAN CALL TO PATIENT 16-30 MINUTES	**$30.00**
PHYSICIAN EMAIL TO PATIENT	**$30.00**
PRESCRIPTION CHANGE OR REFILL REQUEST	**$7.00**

I HAVE RECEIVED A COPY OF THIS FORM AND UNDERSTAND THAT I MAY BE BILLED FOR THE ABOVE CHARGES AND THAT MY INSURANCE WILL NOT BE BILLED.

DATE_____

_____
PATIENT OR LEGAL GUARDIANS SIGNATURE

_____
PRINT NAME

_____
WITNESS