Patient Demographic Form

Last Name: ___________________________First Name: ________________________Middle____________

Address:___________________________ City: _____________ State: _________Zip Code: _____________

Telephone: Home: __________________ Work: _________________Cell: __________________________

Date of Birth: ____________ Age:______Sex: F__ M__ Email:___________________________________

Race:__________________ Ethnicity:_______________________ Preferred Language:________________

SS#: _______________Employer:______________________Occupation:____________________________

Spouse's Name: _______________________Phone:____________________Date of Birth:_____________

Emergency contact: ___________________Phone:____________________Relationship:_____________

Family Doctor Name/Address: _______________________________Phone: ________________________

Pharmacy Name/Address: ___________________________________Phone: ________________________

How were you referred: - TV INS - YP RADIO FRIEND - INTERNET - OTHER _________________

(PLEASE FILL OUT INSURANCE SECTION COMPLETELY)

Primary Ins:_________________________________ Secondary Ins:________________________________

Address:____________________________________ Address:_____________________________________

Phone: ____________________________________ Phone:_____________________________________

ID#:_______________________Grp#____________ ID#:______________________Grp#____________

Insured Name: ___________________DOB:_______ Insured Name: ___________________DOB:_______

NOTE: If your insurance requires a referral or authorization for office visits, it is your responsibility to obtain this prior to your visit.

ASSIGNMENT OF BENEFITS:
I hereby authorize payment directly to Understanding Women, Elizabeth McConnell, M.D. and Laser Surgery Center for all services rendered. I hereby authorize Understanding Women, Elizabeth McConnell, M.D. and/or Laser Surgery Center to release any information required to determine medical benefits payable for services to the organization, the Health Care Financing Administration my insurance carrier or other medical entity. I understand that I am financially responsible to the organization for any charges not covered by my health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment.

Signed:____Date_________________________

Financial Policy

Thank you for choosing our office. We welcome you! We are committed to providing the finest care and professionalism for our patients. Please carefully read and sign the following statement of our financial policy prior to treatment. Feel free to speak to our billing personnel if you have any questions.

The patient or their guarantor is responsible for payment of services that are rendered. If we are a preferred provider on your insurance plan, we will submit the claims to your insurance company and make every attempt to collect with the information that you provide. Please present your insurance card at each visit. **You will be responsible for all co-pay, coinsurance, and deductibles on the day of service.** Should an overpayment occur on the deductible or percentage amounts charged we would apply a credit to your account. A refund is available upon request. If a procedure is scheduled please be aware there will be a **Physician, Facility, Anesthesia and Lab fee**. We will submit for the Physician and Facility. If a procedure is generally deemed to be “cosmetic” or “non medically necessary”, we do not bill insurance companies directly. You must pay for the procedure in full and we will provide you with the necessary paperwork to submit to your insurance company upon request.

IT IS YOUR RESPONSIBILITY TO BE AWARE OF YOUR INSURANCE BENEFITS.

You are ultimately responsible for payment of services rendered if your insurance carrier does not pay for any reason. If you are waiting for coverage to become effective or have no insurance, payment in full will be expected the day you are seen. For your convenience, we accept VISA, MC, Discover or cash.

All insurance information, including prior authorizations and referral forms, must be provided at the time of service and before you are seen. If information is not provided at the time of your appointment you will be rescheduled or considered self pay, your appointment will not be delayed while you obtain the information.

Delinquent accounts over 90 days will be subject to the following action. A collection-processing fee will be added to your outstanding balance and turned over to our collection agency Bureau of Medical Economics for further processing.

FEES: There will be a $40 fee for the following: Electronic copy of medical records to a patient or insurance company.

There will be a $50 service fee for all returned checks. NSF checks must be redeemed with certified funds (cashiers check, money order, certified check or cash).

If you need to cancel a scheduled appointment, please contact our office at least **72 business hours** before your appointment time. Because of high demand for appointments, missed appointments prevent us from scheduling appropriately and to care for others in need of urgent care. **A FEE WILL BE ASSESSED DEPENDING ON THE LEVEL OF COMPLEXITY FOR ALL MISSED APPOINTMENTS NOT CANCELLED WITH AT LEAST 72-BUSINESS HOURS ADVANCE NOTICE.**

REFUNDS FOR AESTHETIC SERVICES: All treatments (Single and/or packages) are Non-Refundable. Unused pre-paid treatments are not eligible for a refund but you may apply the credit toward future services or product.

PRODUCTS PURCHASES: Products are Non-Refundable or Exchangeable.

It is your responsibility to notify our office if there is a change in your insurance coverage, residence, or phone number.

I have read and I understand the Financial Policy and Notice of Privacy Practices and I agree to abide by its terms, a copy will be provided upon patient’s request.

___________________________ Print Name

_______________________________________ Signature of responsible party

______________ Date

Patient Communication Authorization

Patient's Name: ___________________________ Date of Birth: ______________________

We must call on occasion to discuss confidential protected health information. Below is a list of potential ways for us to communicate this information. Please indicate how you would like us to get this information to you:

It's okay to call:

______ Home phone number Leave a message: __ yes __no

______ Mobile/Cell number Leave a message: __ yes __no

______ Work phone number Leave a message: __yes __no

______ Call only this number. ________________Leave a message: __yes __no

______ Do not speak to family members.

I give permission to the individual(s) listed below to receive protected health information:

____

____

This authorization can be revoked or modified by notifying us IN WRITING at any time.

Patient's Signature_______________________________________ Date_________________

MEDICAL HISTORY

Patient Name: ________________________________Marital Status:__________ Age___________D.O.B:______________

Reason for today's visit:____

DrugAllergies:____

Are you allergic to Latex: __ Yes __No   Hepatitis: __Yes __No   HIV: __Yes __No

Past Medical History	**Past Surgical History/Year**	**Family History**	Family Member (Immediate)	**Current Medication/Vitamins Name/Dosage**
__Hypertension	__Gallbladder ________	__Heart Disease	_______	
__Diabetes	__Hemorrhoids ________	__Breast Cancer	_______	**Blood thinners: Yes / No**
__Long term steroid use	__Hysterectomy ________	__GYN Cancer	_______	______________________
__ Seizures	__Heart Surgery ________	__Blood clots in	_______	______________________
__Heart disease	__Pace maker ________	lungs or legs	_______	______________________
__Stroke	__Defribulater ________	__ Colon/Bowel Cancer	_______	______________________
__Cancer	__Prostate ________	__ Stroke	_______	______________________
__Cholesterol disorder	__Bowel Surgery ________	__ Prostate Cancer	_______	______________________
__Thyroid disease	__Tubal ligation ________	__Other___________	_______	______________________
__Kidney disorder	__Thyroid Surgery ________	____________________________		______________________
__Bleeding disorder	__C-section ________	____________________________		______________________
__Lupus/Autoimmune Dis	__Bariatric Surgery ________	____________________________		______________________
__Gout	__Cosmetic(type)____________	____________________________		______________________
__Other_________________	__Other_________________	____________________________		______________________
________________________				

Social History:

__Other_______________   Tobacco use: __Everyday __Some days __Former__ Never

____   ________________________

Patient Signature   **Date**

OFFICE USE ONLY

HT:________________   WT:______________   HGB:___________________

BP:________________   P:________________   PREG TEST:_____________

PROCTOLOGY HISTORY

Patient Name:_____________________________D.O.B:__________________Date:_________________

<u>Date of last</u>

Menstrual Period:______________________________
Pap Smear:____________________________________
Abnormal Pap:___________________Result: __normal __abnormal
Treatment: __burning __freezing __laser
Colonoscopy:_____________________Result: __normal __abnormal
Pelvic US:________________________Result: __normal __abnormal
Endometrial Biopsy:_______________Result: __normal __abnormal
Bone Density Scan:________________Result: __normal __abnormal
Mammogram:_____________________Result: __normal __abnormal

<u>Chief Complaint and Review of Systems</u>

______Hemorrhoids
______Abdominal pain
______Anal itch
______Anal pain
______Anal warts
______Anemia
______Bladder control problems
______Breast mass/discharge
______Constipation
______Fatigue/tired/sluggish
______Fecal incontinence

_______Heavy vaginal bleeding
_______Menopausal symptoms
_______Painful periods
_______PMS
_______Prolapse
_______Rectal Bleeding
_______Rectal drainage
_______Screening Colonoscopy
_______Unable to hold bowels
_______Unable to hold gas

Other_________________
____
____
____

How long have you have you had your symptoms: #____days #____weeks #____months #____years

Onset: ___gradual __sudden

Condition helps with:
___suppositories ___Preparation H ____sitting Helps ___ heat ___ice

Condition results from:
___ pregnancy ___ constipation ____ over lifting ____diarrhea
___ rectal surgery ___ sitting on toilet to long ____ unknown

Severity of condition:
___ unchanged ___improving ___ worsening

Previous treatments:____
Has previous treatments been effective: _____yes ____no

Comments:
____
____
____

____
Patient Signature

Elizabeth McConnell, M.D.
10255 N. 32nd St.
Phoenix, AZ 85028
Tel: (602) 258-7003
Fax: (602) 254-347

____
Patient Name

Do you have a history of?

CARDIAC:

Heart attack? ☐ Yes ☐ No ____

Heart Failure? ☐Yes ☐ No ____

Valve Problem? ☐Yes ☐ No ____

Abnormal herat rhythm? ☐ Yes ☐ No ____

Pacemaker/defibrillator? ☐Yes ☐ No ____

Heart medications? ☐ Yes ☐ No ____

Poor circulation to legs? ☐ Yes ☐ No ____

NEUROLOGICAL:

Stroke or TIA (mini stroke)? ☐ Yes ☐ No ____

Spinal cord injury or problem? ☐ Yes ☐ No ____

Chronic muscle weakness? ☐ Yes ☐ No ____

PULMONARY:

Emphysema/chronic bronchitis? ☐ Yes ☐ No ____

Smoking? ☐ Yes ☐ No How much? ____________________ How long? ______________________________

Asthma? ☐ Yes ☐ No ____

Use of oxygen at home? ☐ Yes ☐ No ____

GENERAL:

Diabetes? ☐ Yes ☐ No ____

Sleep apnea? ☐ Yes ☐ No ____

Cirrhosis of the liver? ☐ Yes ☐ No ____

Kidney disease or dialysis ☐ Yes ☐ No ____

Other significant medical
Problems? (if so, please list) ☐ Yes ☐ No ____

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GENERAL CONSENT FOR MEDICAL AND SURGICAL PROCEDURES

Patient's Performing or Supervising Physician: Elizabeth McConnell, M.D.

Billing procedure (s) that **MAY** be performed if necessary, by the above Surgeon/Physician at the **Elizabeth McConnell, M.D.** if it applies to your condition:

□ **Anoscopy (rectal exam)**

□ **Incision and drainage of abscess**

□ **Evacuation of thrombosed hemorrhoid**

□ **Removal of skin tag**

□ **Banding of hemorrhoid**

This consent form is designed to give permission for either physician in the practice to perform any of the above procedures during the exam if necessary.

1. The McConnell Colorectal Center maintains personnel and facilities to assist the physician and surgeons in their performances of various surgical operations and other special diagnostic procedures. These procedures may all involve risks of unsuccessful results, complications, injury, or even death, from both known and unforeseen causes and no warranty or guarantee is made as to result or cure.
2. The patient's physician/surgeon may recommend the procedures set forth above to be performed, together with any other procedures which in the opinion of the performing physician may be indicated due to an emergency during the course of the procedure. The procedures may also involve the service of the pathologists, who are performing designated duties and are performing such duties in the course of treatment as independent contractors.
3. I consent to the disposal of any organ, tissue sample, member or other item removed from my person during the procedure described above.
4. I understand I may be transferred to the nearest admitting hospital in the event of a life-threatening emergency.
5. In the event that and employee or physician has an accidental needle stick or mucous membrane exposure to my blood or body fluid during the course of my care I consent to a blood sample to be used for testing of HIV or other communicable disease.
6. Just as there may be benefits to the procedure(s) proposed, I also understand that medical and surgical procedures involve risks. These risks include allergic reaction, bleeding, blood clots, infections, adverse side effects of drugs, blindness, and even loss of bodily function or life, as well as risks of transfusion reactions and the transmission of infectious disease, including Hepatitis and Acquired Immune Deficiency Syndrome, from the administration of blood and/or blood components.
7. Acknowledgements: I understand what has been discussed with me as well as the contents of this consent form, and have been given the opportunity to ask questions and have received satisfactory answers.
8. **Consent to Procedures(s) and Treatment:** Having read this, my signature below acknowledges that: I voluntarily give my authorization and consent to the performance of the procedure(s) I have marked above (including the administration of blood and disposal of tissue) by my physician and/or his/her associates assisted trained persons as well as the presence of observers. I also understand that all of the procedures perform are billable procedures.

____ __________________________
Patient Signature (or person authorized to sign for patient) Date