PETER KORETSKY, M.D.
Gastroenterology

Last Name _____ First Name _____ M.I. _____

Street Address _____ City _____ State _____ Zip _____

Phone Number _____ Alternate Phone Number _____

Date of Birth _____ Marital Status ☐ M ☐ S ☐ W ☐ D ☐ Male ☐ Female

Driver's License Number _____ State _____ Social Security Number _____

Employer _____ Occupation _____ Work Number _____

Responsible Party (if other than self) _____ Relationship _____

Responsible Party's Information:

Address _____

Social Security Number _____

Home Phone _____

Work Phone _____

Spouse's Information:

Spouse's Name _____

Employer _____

S.S. Number _____

Occupation _____

Work Phone _____

INSURANCE INFORMATION PRIMARY

Insured Name _____ Self Spouse Parent Other

Card Holder's DOB _____ Name of Insurance Company _____

Insurance Address _____

ID # _____ Group # _____

INSURANCE INFORMATION SECONDARY

Insured Name _____ Self Spouse Parent Other

Card Holder's DOB _____ Name of Insurance Company _____

Insurance Address _____

ID # _____ Group # _____

EMERGENCY CONTACT: PRIMARY

Name _____

Relationship _____

Phone _____

Work Phone _____

EMERGENCY CONTACT: 2ND

Name _____

Relationship _____

Phone _____

Work Phone _____

— continued on back —

PATIENT FINANCIAL POLICY SHEET

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Unless other arrangements have been made in advance by either you or your heath insurance carrier, full payment is due at the time of service. For you convenience we accept [Visa and MasterCard].

Your Insurance

- We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized copayment at the time of service. This office's policy is to collect this copayment when you arrive for your appointment.
- If you have insurance coverage with a plan for which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means that your insurer will send the payment directly to you. Consequently, the charges for your care and treatment are due at the time of service.
- In the event that your health plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
- We will bill your health plan for all services provided in the hospital. Any balance due is your responsibility and is due upon receipt of a statement from our office.

Minor Patients

- For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time.

_____

Printed Name of Patient

_____ _____

Signature of Patient or Responsible Party if Minor Date

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ _____

Signature of Patient or Personal Representative Date

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

CONSENT TO TREAT

My signature below indicates that I hereby give my consent to Peter Koretsky, M.D. to provide medical treatment to the named patient or myself.

INSURANCE AUTHORIZATION

My signature below indicates that I authorize Peter Koretsky, M.D. to release any pertinent medical or health information to the Social Security Administration or its intermediaries, carriers for medical claims, or to my insurance carrier or its representative, any information necessary to process an insurance claim. I permit a copy of this authorization to be used in place of its original and request that payment of medical insurance benefits be made to Peter Koretsky, M.D. Regulations pertaining to Medicare assignment of benefits apply.

STATEMENT ON HIPAA

The Health Insurance Portability Accountability Act (HIPAA) was enacted to protect and enhance the rights of patients by providing them with access to their health information and controlling the inappropriate use of that information to reduce fraud and abuse, and to improve the quality of healthcare by restoring trust in the healthcare system. Peter Koretsky, M.D. will not sell, transfer, copy, distribute or share your personal and health information with any other persons not directly involved in the continuity of your health care without written consent to do so in accordance with HIPAA guidelines. Peter Koretsky, M.D. is committed to implementing measures to comply and adhere to the rules set forth by this act.

APPOINTMENT POLICY

Appointments are reserved especially for you. Peter Koretsky, M.D. makes every effort to schedule times that accommodate your needs. We make every effort to see all patients on time and request you extend the same courtesy. Any changes in the schedule greatly affect our patients. If you are more than 15 minutes late for your appointment, you may be asked to reschedule. We require 24-hour notice for any appointment change. We ask that you make every effort to comply with this policy. Consistently missed appointments may result in a formal discharge from this practice. My signature below indicates that I have read and agree to abide by the terms of this Appointment Policy.

My signature below indicates that I have read and agree to abide by the terms of this agreement

Signature of Patient or Responsible Party if Minor

Date

PATIENT SELF DETERMINATION ACT QUESTIONNAIRE

DON'T LOSE YOUR RIGHT TO DECIDE!

You cannot remove all uncertainty about your future healthcare needs, but by having an advance directive you can have the peace of mind that comes from making your wishes known in advance!

Declaration to Decline Life-Prolonging Procedures (Living Will)

☐ I have made a Living Will

☐ I do **NOT** have a Living Will

Health Care Surrogate

☐ I have designated a Health Care Surrogate

☐ I have **NOT** designated a Health Care Surrogate

Durable Power of Attorney

☐ I have appointed a Durable Power of Attorney for Health Care decisions

☐ I have **NOT** appointed a Durable Power of Attorney for Health Care decisions

_____ _____

Signature of Patient or Representative Date

If you have any further questions, you can contact your family attorney, local hospital, or local medical association for additional information.

ASSIGNMENT OF BENEFITS FORM

FINANCIAL RESPONSIBILITY

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

ASSIGNMENT OF BENEFITS

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Dr. Koretsky for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Dr. Koretsky to: (1) release any information necessary to insurance carriers regarding my illness an treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Dr. Koretsky on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

_____ _____

Signature of Patient or Responsible Party if Minor Date

_____ _____

Witness Date

MEDICATION CHART

Patient Name _____ Allergies: _____

Date of Birth _____ _____

_____

Update medication list on every visit. _____

MEDICATION	DOSE	ROUTE	FREQUENCY	DATE DISCONTINUED

HEALTH HISTORY QUESTIONNAIRE

Patient Name _____ DOB _____ Today's Date _____

Past Medical/Surgical History:
Please list all past and present medical/surgical problems. Please be as thorough as possible.

Medical Problems	Date

Previous Surgery	Date

Please list all medications.
Include vitamins, herbs and others.

Medications	Dose	Frequency

List all known allergies

Allergy	Reaction

Check all previous or current digestive problems:

___ Colon Cancer
___ Colon Polyps
___ Rectal Bleeding
___ Hemorrhoids
___ Diverticulosis
___ Constipation
___ Diarrhea
___ Bowel Changes
___ Ulcerative Colitis
___ Colitis
___ Crohn's Disease
___ Anemia
___ Difficulty/Painful Swallowing
___ Reflux or Heartburn
___ Hiatal Hernia
___ Stomach Ulcers
___ Esophageal Cancer
___ Esophageal Stricture
___ Barrett's Esophagus
___ Wt. Loss
___ Liver Problems
___ Hepatitis
___ Jaundice
___ Abdominal Pain

Have you ever had a blood transfusion? Y or N
If so, when? _____

Have you ever had a colonoscopy? Y or N
If so, when? _____

Have you ever had an endoscopy? Y or N
If so, when? _____

Do you drink alcohol? Y or N
Drinks/day_____ /week_____ Years?_____

Do you use tobacco? Y or N
Number per day?_____ Years? _____

Daily/Weekly consumption:

Caffeine_____

NSAIDs (aspirin, motrin, ibuprofen, advil)

_____

Social History

Marital Status:

Married ___ Single ___ Divorced ___ Widowed ___

Number of Children _____

Ages of Children _____

Level of Education: _____

Occupation: _____

If any, Religious Preference? _____

Hobbies _____

Family History (Check those that apply)

	Father	Mother	Siblings	Children	Father's Parents	Mother's Parents
Cancer	☐	☐	☐	☐	☐	☐
Colon Cancer	☐	☐	☐	☐	☐	☐
Esophageal Cancer	☐	☐	☐	☐	☐	☐
Stomach Cancer	☐	☐	☐	☐	☐	☐
Liver Disease	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐

Review of Symptoms: Check all symptoms that you frequently or presently have.

1. Eyes
___ worsening vision
___ double vision
___ cataracts

2. Ears
___ hearing difficulties
___ ringing in ears

3. Mouth
___ dental problems
___ bleeding gums

4. Nose
___ nose bleeds
___ congestion

5. Head
___ headaches
___ sinus problems

6. Neck
___ pain or stiffness
___ swelling

7. Throat
___ hoarseness

8. Lungs
___ wheezing
___ shortness of breath
___ chronic cough
___ coughing blood
___ history of tuberculosis

9. Heart
___ chest pain
___ palpitations
___ racing heart beat
___ irregular heart beat
___ heart murmur
___ dizzy spells
___ swollen ankles

10. Digestive
___ black stools
___ nausea/vomiting
___ stomach pains
___ vomiting blood
___ diarrhea
___ constipation

11. Urinary Tract
___ frequent urination
___ incontinence
___ kidney stones
___ burning

12. Male Genitalia
___ discharge
___ sores on penis
___ painful testicles
___ prostate trouble

13. Female Genitalia
___ discharge
___ menstrual problems
___ vaginal bleeding

14. Breast-Male & Female
___ soreness
___ discharge
___ history of cancer

15. Musculoskeletal
___ painful joints
___ back pain
___ muscle aches
___ stiffness

16. Skin
___ itchiness
___ bruising

17. Neuro
___ fainting
___ tremors
___ memory loss

18. General
___ wt. loss
___ wt. gain
___ fatigue
___ chills
___ fever

19. Ankle/Foot
___ pain
___ swelling

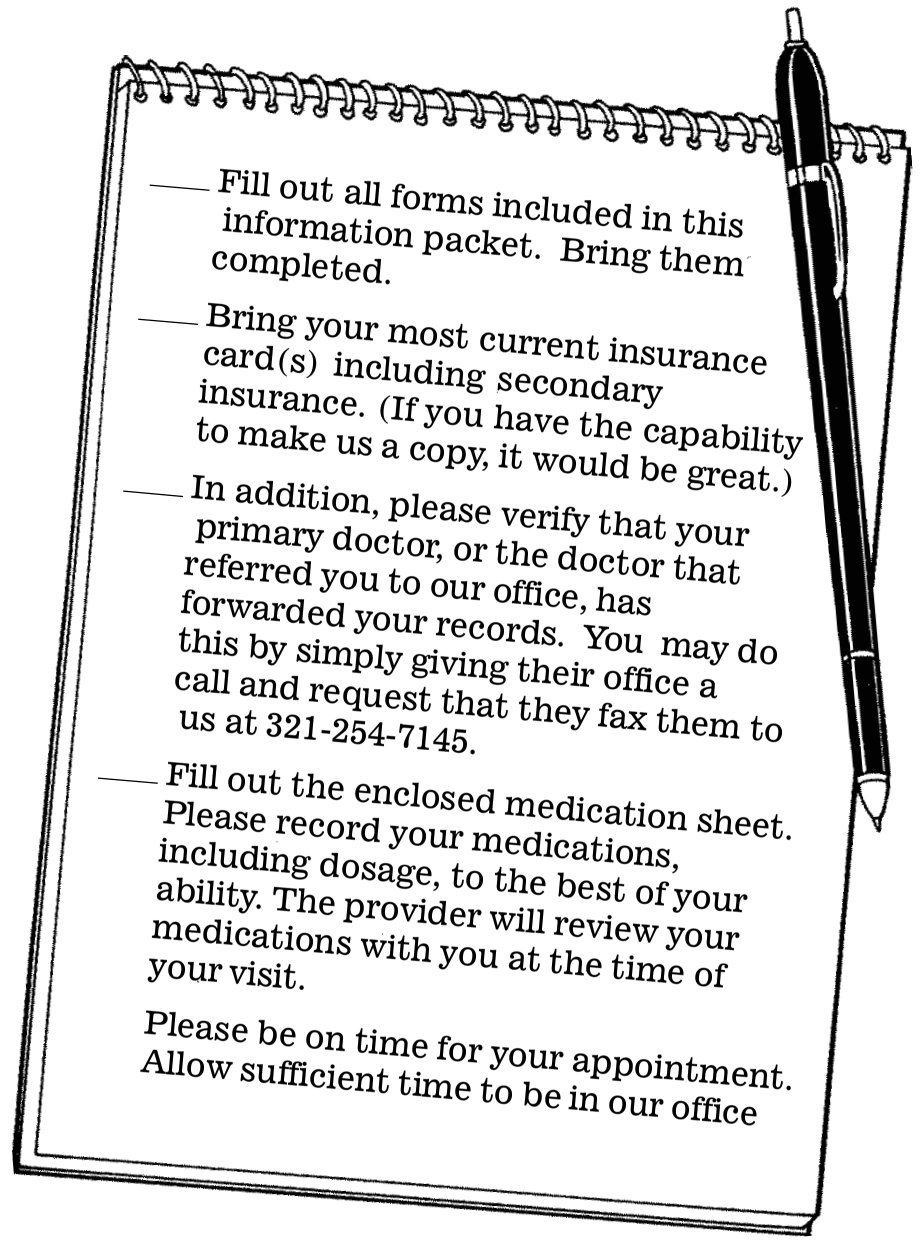
20. Sleep
___ snoring
___ insomnia

Peter A. Koretsky, M.D., P.A.
2955 Pineda Causeway, Suite 115 • Melbourne, FL 32940 • (321) 254-7375 • Fax (321) 254-7145

WELCOME

Welcome to the practice of Dr. Peter Koretsky, M.D. and Jill Polet, ARNP. Whether you are a new patient to our practice or a returning patient of Dr. Koretsky and Jill, please fill out this new patient packet prior to arriving for your appointment. Enclosed are a map and a business card with the date and time of your appointment.

We would like once again to welcome you to our practice and thank you for entrusting us with helping you with your gastroenterology-related health issues. We look forward to seeing you in our office.



Things to Know When Calling the Office

Medication Refills

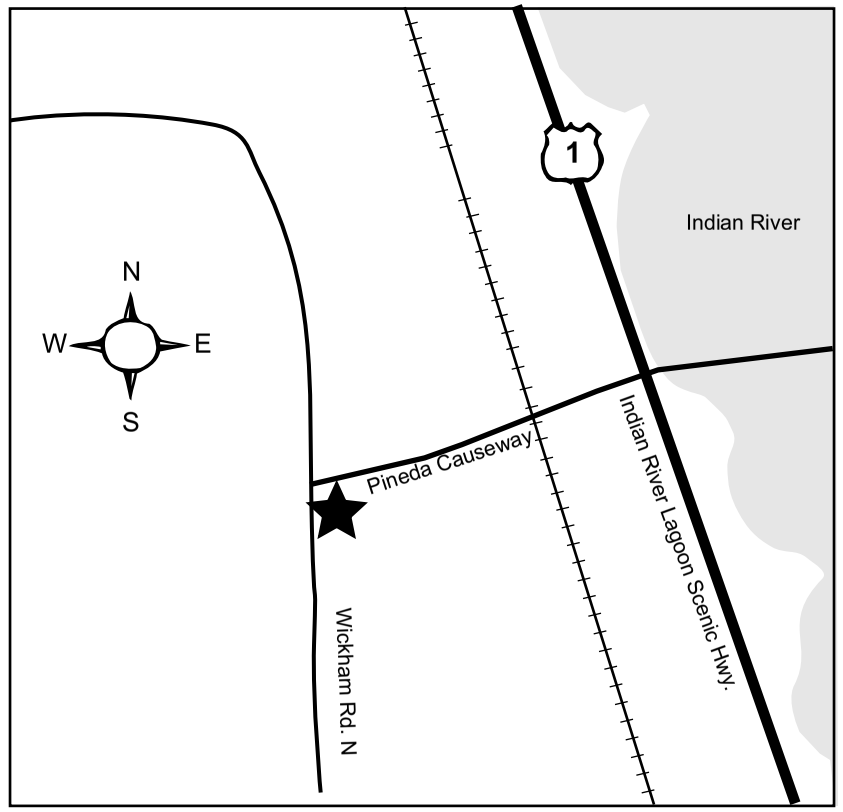
It is very important that you do not run out of medications that need to be taken on a regular basis. Here are some helpful hints that will guide you through a prescription refill.

- Do not wait until your medication runs out to call in your refill request.
- Please tell the office your full name, correct spelling of your name, your date of birth, and your phone number when calling in your request.
- Please tell the office the name of the medication, dose, quantity needed, and how the medication is taken.
- Please tell the office the pharmacy name and phone number.
- Inform the staff of any and all allergies at the time of your request.
- Allow 48 hours for the prescription refill to be called in.
- Plan ahead — notify the office of the medication needed at lest seven (7) days before the medication runs out.
- Please take into consideration the delay in "mail refills" when requesting a written prescription refill.
- Prescription refills will only be called in during regular business hours Monday through Friday.
- Unless emergent, prescription refills will not be called in over the weekend or after regular office hours.
- Prescription refills will not be called in to out-of-state pharmacies.
- Patients must have been seen in the office within 12 months, or sooner if your doctor requests, before the prescriptions will be called in.

Phone Calls About Specific Health Concerns

It is our goal to provide patients with quality medical services. Your cooperation can help us take care of you and your family in an appropriate and timely manner and avoid any delays. Here are some helpful hints that will guide you through phone calls to the office about health concerns.

- If you believe that you have a medical emergency, dial 911 and tell the emergency department who your doctor is when you arrive.
- When calling the office, state your name, problem or concern, any symptoms associated with your concern, and how long you've been experiencing it.
- Please be as detailed as possible — often times return calls may not be made until the end of the day, so the office staff will need as much information as possible to assess these situations over the phone.
- During evenings, weekends, and holidays, Dr. Koretsky or his coverage will be available to assist you with your needs.
- On-call physicians or providers will assist you with medical problems that need **immediate attention.** If appropriate, please try to call the office during regular business hours.
- Office information: **Dr. Peter Koretsky, MD**
  2955 Pineda Causeway, Ste. 115, Melbourne, FL 32940
  Phone (321) 254-7375 Fax (321) 254-7145



Peter Koretsky, M.D.
Gastroenterology

Board Certified Gastroenterology
Digestive Diseases
Colonoscopy
Endoscopy

DR. KORETSKY
AUTHORIZATION FOR RELEASE OF
PROTECTED HEALTH INFORMATION

- Medical records are to include any and all Federal and State protected information without limitation, to include diagnosis, treatment and/or alcohol abuse, HIV testing/ AIDS, and sexually transmitted diseases.
- By signing this release, you understand that this authorization will remain in effect until revoked in writing. Dr. Koretsky is authorized to use outside vendors for the purpose of copying and providing the information requested.
- I understand that the law prohibits the re-disclosure of the information disclosed to the persons/entities listed above without my further authorization, but that Dr. Koretsky cannot guarantee that the recipient of the information will not re-disclose this information contrary to such prohibition.
- I understand I have the right to inspect and obtain a copy of any information disclosed.
- I hereby release Dr. Koretsky and his employees from any and all liability that may arise from the release of information as I have directed.
- I understand that if I have requested duplication of records within a one year time period (of the same or similar records), I may be charged a fee of up to $1.00 per page for every page copied. This fee may be waived for copies provided to a health care provider, insurance company or other specific organizations for treatment, billing or operations purposes.

Signature of Patient: Date:

Empowered Representative: Date:

Relationship to Patient:

Witness:

Request Processed by: (initials) Date:

Copied Date:

2955 Pineda Causeway, Suite 115 • Melbourne, FL 32940 • (321) 254-7375 • (321) 254-7145 Fax

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Gastroenterology
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Phone (321) 254-7375 • Fax (321) 254-7145

Authorization to Release / Obtain Medical Records

Patient Name _____ Date of Birth _____

Social Security # _____ Phone _____

Purpose of Release: _____

I hereby authorize **Peter Koretsky, MD,** to: release to / obtain from
Please circle

Name: _____

Address: _____

City, State, Zip: _____

any information, including diagnosis and medical records of any treatment or examination rendered to me during the following period:

( ) the past twelve (12) months, OR

( ) from the time period from _____ to _____

and to include any Federal and State protected information under Florida Statute 394-459(9) Psychiatric information, Florida Statute 397-501, and Florida Statute 397.112 Drug and/or Alcohol Abuse information, and Florida Statute 381.004 and FAC IOD-93.064 Human Immunodeficiency Virus test results (HIV testing, AIDS, and related conditions).

- I understand and direct that this authorization remain in effect until I revoke the authorization in writing to the Privacy Officer at the address above.
- I understand that the information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer protected by HIPAA.
- I hereby release **Peter Koretsky, MD** and his employees from any and all liability that may arise from the release of this information as I have directed.

Signature _____ Date _____
(patient, parent, or guardian)

Relationship to Patient if signed by personal representative: _____

Witness: _____ Date: _____

( ) Please check here if records will be picked up. Someone will call you when records are ready.

( ) Please check here if records are to be mailed.

For office staff only: ( ) Send certified / return receipt. Date mailed: _____

Article #: _____