ADVANCED GASTROENTEROLOGICAL ASSOCIATES

M. Badar Anwer, M.D.

210 E. Monument Ave, Suite A
Kissimmee, FL 34741
Phone: 407-870-9992
Fax: 407-870-5153

410 Celebration Place, Suite 400
Celebration, FL 34747
Phone: 407-566-0700
Fax: 407-566-0712

Welcome To Our Practice!

We are so glad that you chose our Practice for your medical needs. It is important to us that you have an experience while being a patient of ours that exceeds your expectations. We want you to be actively involved in your plan of care that you and Dr. Anwer will jointly discuss and develop.

It is essential for you and our staff to be able to communicate with each other in an easy and effective manner. We want you to know that any question's you may have are very important to us and our goal is to be able to communicate with you regarding your questions on a timely basis.

We, therefore, want to share with you the most effective way for you to communicate with Dr. Anwer and any member of the staff. We offer different ways for you to communicate with us so we can respond to your inquiries at our very earliest convenience.

For scheduling your initial office visit with our Practice calling us directly at our Celebration or Kissimmee office was the best method. Now that your appointment has been scheduled with us if you have any further questions we recommend that you use one of our email addresses. For questions related to your scheduled office visit only such as verifying or changing your appointment time, insurance coverage, etc. use email address: Reception@anweraga.com. If you have been scheduled for surgery/procedure and have any questions related to your upcoming surgery/procedure use email address: Backoffice@anweraga.com.

Of course if you don't have access to email, please do not hesitate to call us at either one of our offices: Celebration 407-566-0700 or Kissimmee 407-870-9992. If you only need directions to one of our offices you may call either office or press 5 for directions to the Kissimmee office and press 6 for directions to the Celebration office. Should you have any questions after your care with us has been completed you can use our email address: Reception@anweraga.com or one of our telephone numbers.

We look forward to meeting you when you come to our office for your scheduled office visit. We assure you that we will do everything to make your visit and experience as comfortable for you as we possibly can.

Sincerely,

Dr. Anwer and Staff

Advanced Gastroenterological Associates

Gastroenterology, Hepatology, Therapeutic & Biliary Endoscopy
Diagnostic & Interventional Endoscopic Ultrasound

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Phone 407-566- 0700 Fax 407-566-0712
Website: dranwer.com

Name: ____________________________DOB:_________________ Sex: _______ Race: ________

SSN: ____________________________________ Marital Status: ____________ Age: ____________

Address: ____

City: ____________________________________ State: ___________________ Zip Code: _________

Home Phone: ______________________ Work Phone: _____________Cell Phone: _______________

Email: _________________________________ Employer: __________________________________

Occupation: ____________________________ Referring Physician: ___________________________

Emergency Contact Information

Name: _______________________________________ Relationship: ___________________________

Home Phone: _______________________ Work Phone: ________________ Cell Phone: ___________

Insurance Information

Insurance Carrier: ____________________________________ Phone: ________________________

Address: ____

Policy ID Number: _____________________________________Group Number: __________________

Insured Name: ____ DOB: _____________________

SSN: _______________________________ Relationship to Insured: __________________________

Signature: ____ Date: _______________________

Advanced Gastroenterological Associates
M. Badar Anwer, M.D.
Diplomat American Board of Gastroenterology

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Medical Consent

I, ______________________________________, hereby authorize Advanced Gastroenterological Associates to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out treatment, payment and health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, Advanced Gastroenterological Associates can refuse to treat me.

I have received a copy of the Notice of Privacy Standards ("Notice") which more fully describes the uses and disclosures that can be made of individually identifiable health information for treatment, payment and health care operations. I have fully understood my rights to the privacy practice I understand that if I wish a copy of this notice, I have the right to request one.

I understand that I may revoke this consent at any time by notifying Advanced Gastroenterological Associates, in writing, but if I revoke my consent, such revocation will not affect any actions that Advanced Gastroenterological Associates took before receiving my revocation.

I understand that Advanced Gastroenterological Associates has reserved the right to change its privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request that Advanced Gastroenterological Associates restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that Advanced Gastroenterological Associates does not have to agree to such restrictions, but that once such restrictions are agreed to, Advanced Gastroenterological Associates must adhere to such restrictions.

I understand that in case of medical emergency I will call 911 and go to the nearest emergency facility and for Non-emergency needs I will call the office during business hours.

A broken appointment is loss to everyone. Please inform us 24 hours in advance if you are unable to keep your appointment. Patient who fail to give sufficient notice will be charged a fee of $25.00 for a broken appointment.

I hereby authorize direct payment of medical/surgical benefits to Advanced Gastroenterological Associates for services rendered by Dr. Anwer in person or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance.

I hereby authorize Advanced Gastroenterological Associates to release any medical, financial or incidental information that may be necessary for either medical care or in processing application for financial benefits.

Unless specified, I hereby grant permission to Advanced Gastroenterological Associates or its representatives to leave messages about my healthcare status to myself, referring providers, and/or authorized person via phone calls, voicemails, answering machines, or email address provided.

I hereby authorize Advanced Gastroenterological Associates to use the clinical information about me for the research and academic purposes.

(Medicare & Medicaid) I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits to be paid on my behalf.

Payment is required at the time of services unless prior arrangements have been made.

A photocopy of this document shall be valid as the original

At any point during patient-doctor relation, the patient has the right to seek a second medical opinion.

Medical science is a rapidly growing and changing field; the recommendations may vary from time to time.

Signature of patient or patient's representative: ______________________________ **Date:** __________

Printed name of patient or patient's representative: ______________________________

Relationship to patient: ______________________________

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Financial Policy & Consent

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies.

1. Payment is due at the time of service unless arrangements have been made in advance with the Practice. We accept the following types of payment: cash, check, debit/credit card (Visa, MasterCard and Discovery).

2. We have made prior arrangements with most insurance companies and health plans to accept an assignment of benefits. Therefore you are authorizing direct payment of medical/surgical benefits to Advanced Gastroenterological Associates for all services rendered by the physician or under his supervision. We will bill your insurance carrier but you are required to pay applicable, deductibles copayments, or coinsurances prior to services being rendered. You will also be responsible for any balance not covered by your insurance.

3. In most cases a written referral or prior authorization is required from the physician making your referral to our Practice. This is required by your insurance carrier in order for us to properly process your claim. It is your responsibility to provide us with this written information. If we haven't received this information in our Office prior to your scheduled appointment we may need to reschedule your appointment and a cancellation fee may be assessed.

4. If you are having a procedure our normal policy will be for you to pay a deposit toward your "out of pocket" expenses required by your Health Plan and prior to services being rendered.

5. If you choose to pay your bill "out of pocket" meaning, you are a self-pay patient, you will need to provide payment in full prior to services being rendered.

6. If you are insured by a health plan that we are not contracted with you have two options: 1) We will prepare and send the claim for you on an unassigned basis, or 2) We will provide you with a claim so you can bill your Health Plan. With either option payment for your care is due in full prior to services being rendered.

7. Your insurance policy basically is a contract between you and your insurance company and as a service to you, we will file your insurance claim if you assign the benefits to the doctor meaning you are authorizing your insurance company to pay the doctor directly. If your insurance company does not pay the Practice within a reasonable period, we will have to look to you for payment. If we later receive payment from your insurance company, we will refund any overpayment to you.

8. Not all insurance carriers or health plans cover all services. In the event of your Health Plan determines a service to be "no covered", you will be responsible for the complete charge. Payment in full is due upon receipt of a statement from our Office.

9. If you miss a scheduled appointment the Practice and other patient's needing an appointment are affected. Therefore, please, provide us with a minimum of 24 hour advance notice if you are unable to keep your appointment. If you fail to provide us with this notice you will be charged a $25 "no show" fee.

10. During the course of your treatment you may be rendered services by other providers requested by the doctor and therefore you will receive a bill directly from these providers. Some of those providers may be: Celebration Outpatient Center, Kissimmee Surgery Center, pathology laboratory, radiologist, anesthesiologist, hospital, other physician consultants/specialists, etc.

11. There will be a $35 fee assessed for insufficient funds if you pay by check.

12. There will be a fee of $15-$25 for completing a medical form, disability, work restriction, etc. and a notice of 5 to 7 business days is required.

13. We will send copies of your medical records directly to your Primary Care physician at no cost. If you want a personal copy, or copies sent to other physicians there will be a fee of $1 per page up to 25 pages, and 25 cents for all additional pages. We will need a notice of 5 to 7 business days. Regulations also require that we obtain a signed written request from the patient or patient sign consent at the Office.

14. It is your responsibility to provide us with accurate demographic and insurance coverage information. If we are unable to make contact with your insurance company it becomes your responsibility to obtain and then provide us with correct information. It is also your responsibility to notify our office any contact information changes such as address, phone numbers, emails, and insurance information.

If you have any questions concerning this notice, please feel free to ask for additional information from your physician or any representative of Advanced Gastroenterological Associates.

I have read and understand the "Financial Policy & Consent" and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the Practice.

____

Signature of patient (or responsible party) **Date**

____

Please print the name of the patient

Name ______________________________ Date ______________

REVIEW OF SYSTEMS

Keys: Y-Yes, N-No, DK-Don't Know

CONSTITUTIONAL

Y N DK

- ☐ ☐ ☐ Do you have a fever?
- ☐ ☐ ☐ Did you lose weight?
- ☐ ☐ ☐ Did you gain weight?
- ☐ ☐ ☐ Do you feel tired and fatigued?
- ☐ ☐ ☐ Do you feel loss of energy?
- ☐ ☐ ☐ Do you feel dizziness?
- ☐ ☐ ☐ Do you have headaches?

EYES, EARS, NOSE, THROAT

- ☐ ☐ ☐ Do you have vision problem?
- ☐ ☐ ☐ Did you have eye pain?
- ☐ ☐ ☐ Did you wear prescription glasses?
- ☐ ☐ ☐ Do you wear contact lenses?
- ☐ ☐ ☐ Do you have double vision?
- ☐ ☐ ☐ Do you have hearing problems?
- ☐ ☐ ☐ Do you have ringing in ear?
- ☐ ☐ ☐ Did you have vertigo?
- ☐ ☐ ☐ Do you have ear pain?
- ☐ ☐ ☐ Do you or did you have nose or gum bleeding?
- ☐ ☐ ☐ Do you have sinus problem?
- ☐ ☐ ☐ Do you have hoarseness?

PULMONARY

- ☐ ☐ ☐ Do you have a cough?
- ☐ ☐ ☐ Did you have sputum/phlegm?
- ☐ ☐ ☐ Did you get short of breath at mild exertion?
- ☐ ☐ ☐ Do you get short of breath when you are laying down?
- ☐ ☐ ☐ Do you get short of breath at night when you are sleeping?

CARDIOVASCULAR

- ☐ ☐ ☐ Did you/Do you have chest pain at rest?
- ☐ ☐ ☐ Did you/Do you have chest pain at exertion?
- ☐ ☐ ☐ Did you/Do you have palpitation?
- ☐ ☐ ☐ Do you pass out?

HEMATOLOGICAL

- ☐ ☐ ☐ Do you have a tendency to bleed easily?
- ☐ ☐ ☐ Do you have a tendency to bruise easily?
- ☐ ☐ ☐ Did you/Do you have calf pain?
- ☐ ☐ ☐ Did you/Do you have swelling in your feet and legs?

GASTROENTEROLOGICAL AND HEPATIC

- ☐ ☐ ☐ Did you/Do you have difficulty in swallowing?
- ☐ ☐ ☐ Did you/Do you have pain when you swallow?
- ☐ ☐ ☐ Did you/Do you have excessive salivation?
- ☐ ☐ ☐ Did you/Do you have bad breath?
- ☐ ☐ ☐ Did you/Do you have heart burn?
- ☐ ☐ ☐ Did you/Do you have regurgitation?
- ☐ ☐ ☐ Did you/Do you have nausea?
- ☐ ☐ ☐ Did you/Do you have vomiting?
- ☐ ☐ ☐ Did you ever vomit blood, coffee colored substance?
- ☐ ☐ ☐ Did you/Do you have abdominal pain?
- ☐ ☐ ☐ Did you/Do you have any change in bowel habit?
- ☐ ☐ ☐ Did you/Do you have diarrhea?
- ☐ ☐ ☐ Did you/Do you have constipation?
- ☐ ☐ ☐ Did you ever pass black stool?
- ☐ ☐ ☐ Did you/Do you have rectal bleeding?
- ☐ ☐ ☐ Did you/Do you have pain in your rectum when you move your bowels?

ENDOCRINE

- ☐ ☐ ☐ Do you have intolerance to cold?
- ☐ ☐ ☐ Did you have intolerance to heat?
- ☐ ☐ ☐ Are you having excessive urination?
- ☐ ☐ ☐ Are you unusually thirsty?
- ☐ ☐ ☐ Are you overeating?

UROGENITAL

- ☐ ☐ ☐ Do you wake up at night to urinate?
- ☐ ☐ ☐ Do you have difficulty in urination?
- ☐ ☐ ☐ Do you have pain or burning while urinating?
- ☐ ☐ ☐ Do you see blood in urine?
- ☐ ☐ ☐ Did you see any change in color of urine?
- ☐ ☐ ☐ Do you have urethral discharge?
- ☐ ☐ ☐ Do you have dysmenorrhea?

MUSCULOSKELETAL

- ☐ ☐ ☐ Do you have joint pain?
- ☐ ☐ ☐ Do you have muscular pain?
- ☐ ☐ ☐ Do you have pain in your legs when you walk?
- ☐ ☐ ☐ Do you have cold feet?

DERMATOLOGICAL

- ☐ ☐ ☐ Did you/Do you have rashes?
- ☐ ☐ ☐ Do you have pruritus (itching)?

NEUROLOGICAL

- ☐ ☐ ☐ Do you have weakness?
- ☐ ☐ ☐ Do you have numbness?

M.D. Init.__________

Name ______________________________ Date ______________

PAST HISTORY

Please fill out as complete and accurate as possible. Ask for assistance.
Keys: Y-Yes, N-No, DK-Don't Know

Y	N	DK	
☐	☐	☐	Do you have any allergies? If yes please list. ______________
☐	☐	☐	Did you have measles?
☐	☐	☐	Did you have rubella
☐	☐	☐	Did you have rheumatic fever?
☐	☐	☐	Did you have mumps?
☐	☐	☐	Did you have chicken pox?
☐	☐	☐	Did you/Do you have seizure disorder?
☐	☐	☐	Did you have a stroke?
☐	☐	☐	Did you/Do you have cataracts?
☐	☐	☐	Did you/Do you have glaucoma?
☐	☐	☐	Do you wear removable dentures?
☐	☐	☐	Did you/Do you have neck problems?
☐	☐	☐	Did you/Do you have any lung problem?
☐	☐	☐	Did you/Do you have tuberculosis?
☐	☐	☐	Did you have pneumonia?
☐	☐	☐	Did you/Do you have asthma?
☐	☐	☐	Did you/Do you have chronic obstructive disease?
☐	☐	☐	Are you on oxygen therapy?
☐	☐	☐	Did you/Do you have any heart problem?
☐	☐	☐	Do you have hypertension (high blood pressure)?
☐	☐	☐	Do you have angina?
☐	☐	☐	Did you have a heart attack?
☐	☐	☐	Do you have a murmur?
☐	☐	☐	Do you have a pacemaker?
☐	☐	☐	Did you have cardiac arrest?
☐	☐	☐	Did you have bypass surgery?
☐	☐	☐	Do you have an artificial valve in your heart?
☐	☐	☐	Did you receive a blood transfusion?
☐	☐	☐	Are you on Warfarin (Coumadin)?
☐	☐	☐	Are you on aspirin, aspirin-like medicines?
☐	☐	☐	Are you on Heparin?
☐	☐	☐	Are you on Plavix?
☐	☐	☐	Did you/Do you have any cancer?
☐	☐	☐	Did you/Do you have abdominal or digestive problem?
☐	☐	☐	Did you/Do you have an acid reflux problem?
☐	☐	☐	Did you/Do you have stomach ulcer?
☐	☐	☐	Did you/Do you have colonic polyp?
☐	☐	☐	Did you/Do you have colonic cancer?
☐	☐	☐	Did you have a colonoscopy? If yes, when? ______________
☐	☐	☐	Did you have gastroscopy done? If yes, when? ______________
☐	☐	☐	Did you/Do you have hemorrhoids?
☐	☐	☐	Did you have surgery for gall bladder problem?
☐	☐	☐	Did you have surgery for problem with appendix?
☐	☐	☐	Did you/Do you have hepatitis?
☐	☐	☐	Did you receive blood transfusion before 1990?
☐	☐	☐	Do you have pancreatitis?
☐	☐	☐	Do you have diabetes mellitus?
☐	☐	☐	Do you have high cholesterol?
☐	☐	☐	Do you have hypothyroidism (low thyroid activity)?

Name all the medications, prescriptions or nonprescriptions, you are taking: ______________

____

____

____

SOCIAL HISTORY

Y	N	DK	
☐	☐	☐	Did you/Do you smoke? If yes how many cigarettes/packs per day?__________ For how many years__________
☐	☐	☐	Did you/Do you drink alcoholic beverages?
☐	☐	☐	Did you try to cut back?
☐	☐	☐	Did you get annoyed discussing alcoholism?
☐	☐	☐	Did you/Do you feel guilty?
☐	☐	☐	Did you/Do you drink alcohol in the morning?
☐	☐	☐	Did you/Do you use recreational drugs?
☐	☐	☐	Did you/Do you have casual, unprotected sex?
☐	☐	☐	Did you/Do you have anal sex?
☐	☐	☐	Are you heterosexual?
☐	☐	☐	Are you homosexual?
☐	☐	☐	Are you bisexual?

What do you do for a living?______________

Y	N	DK	
☐	☐	☐	Are you retired?
☐	☐	☐	Did you travel outside the United States? When and where? ______________

____

____

M.D. Init.__________

Name ______________________________ Date ______________

FAMILY HISTORY

Please fill out as complete and accurate as possible. Ask for assistance.
Keys: Y-Yes, N-No, DK-Don't Know

Y	N	DK		Y	N	DK	
☐	☐	☐	Reflux disease	☐	☐	☐	Colonic polyp
☐	☐	☐	Colonic cancer	☐	☐	☐	Pancreatitis
☐	☐	☐	Pancreatic cancer	☐	☐	☐	Hepatitis
☐	☐	☐	Cirrhosis				

	Alive	Deceased	Cause of Death	Age	Diseases
Mother	☐	☐	______	______	______
Father	☐	☐	______	______	______
Brothers	☐	☐	______	______	______
______1.	☐	☐	______	______	______
______2.	☐	☐	______	______	______
______3.	☐	☐	______	______	______
______4.	☐	☐	______	______	______
______5.	☐	☐	______	______	______
Sisters	☐	☐	______	______	______
______1.	☐	☐	______	______	______
______2.	☐	☐	______	______	______
______3.	☐	☐	______	______	______
______4.	☐	☐	______	______	______
______5.	☐	☐	______	______	______
Sons	☐	☐	______	______	______
______1.	☐	☐	______	______	______
______2.	☐	☐	______	______	______
______3.	☐	☐	______	______	______
______4.	☐	☐	______	______	______
______5.	☐	☐	______	______	______
Daughters	☐	☐	______	______	______
______1.	☐	☐	______	______	______
______2.	☐	☐	______	______	______
______3.	☐	☐	______	______	______
______4.	☐	☐	______	______	______
______5.	☐	☐	______	______	______

M.D. Init.__________

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Patient Medication History Form

Patient Name:	Date of Birth:	Date:

Allergies/Adverse effects to Medication:

Current Medications

Name of Medicine	Dosage	Frequency

Preferred Pharmacy: (Name and Telephone)

____