



# INFINITY SURGICAL ASSOCIATES

Reason for Visit: \_\_\_\_\_

PATIENT NAME: FIRST		M.I.	LAST	DATE OF BIRTH	SOCIAL SECURITY #		MALE / FEMALE? M or F
HOME ADDRESS			APT #	CITY	STATE	ZIP	HOME PHONE
EMPLOYER				ADDRESS			WORK PHONE
OCCUPATION				REFERRED BY: FIRST and LAST NAME			CELL PHONE
ALLERGIES TO MEDICATIONS			PERSONAL PHYSICIAN: FIRST and LAST NAME (Give address and Phone if known)			MARITAL STATUS ___S ___M ___W ___D	
SPOUSES NAME				WORK PHONE:		OCCUPATION	
PERSON TO CONTACT IN CASE OF EMERGENCY (NOT RESIDING WITH YOU)						TELEPHONE	
POLICY HOLDER NAME			SOCIAL SECURITY NUMBER		DATE OF BIRTH	FINANCIALLY RESPONSIBLE PERSON ___PATIENT ___SPOUSE ___PARENT ___OTHER	
EMPLOYER				ADDRESS			WORK PHONE

## Primary Insurance Billing Information

## Secondary Insurance Billing Information

<b>Ins. Co. Name</b> _____ <b>Address:</b> _____ <b>City, State &amp; Zip:</b> _____ <b>ID.No:</b> _____ <b>Group Name:</b> _____ <b>Group #</b> _____ <b>Subscriber:</b> _____ (Person's Name) <b>Subscribers Date of Birth:</b> _____ <b>Subscriber's Social Security #</b> _____	<b>Ins. Co. Name</b> _____ <b>Address:</b> _____ <b>City, State &amp; Zip:</b> _____ <b>ID.No:</b> _____ <b>Group Name:</b> _____ <b>Group #</b> _____ <b>Subscriber:</b> _____ (Person's Name) <b>Subscribers Date of Birth:</b> _____ <b>Subscriber's Social Security #</b> _____
---	---

### PAYMENT POLICY

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the Patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance with our office. In the event my account is turned over to an attorney for collections, I will pay any fee/costs incurred during the collection process.

### INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Giath Alshkaki, MD, to furnish information to insurance carriers (including Medicare/Medigap) concerning my illness and treatments and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurances.

**The information I provided above is correct.**







**REQUEST FOR MEDICAL RECORDS/ RELEASE OF INFORMATION FORM**

The undersigned patient or patient representative agrees to the following terms regarding all general and specific information transmission, and/or requests that medical records are delivered to the specified location. I understand that a fee may apply for specific requests.

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Social Security Number \_\_\_\_\_

Records Requested:

Any records requested deemed necessary for the pre-operative and post-operative evaluation and management of a patient's case. Records may be sent to referring physicians, specialists, hospitals, pre-op centers, insurance or financing agencies, or any other entity that needs such information for the patient's care or other financial purposes. The modality of record delivery may include phone conversation, fax, e-mail, US mail, UPS, or other courier service. I understand that any of these delivery modalities is not perfect and that the records may reach persons or entities other than those requested. I understand that Dr. Alshkaki and his employees are acting in good faith and I certify that I will indemnify and hold Dr. Alshkaki and his employees harmless for any such delivery errors.

**I agree to receive e-mail/faxes regarding my medical condition from my doctor or Dr. Alshkaki. I understand that when I communicate via e-mail, that response times may be significantly slow and delayed and that I will not depend on this modality for time sensitive communication or urgent problems.**

\_\_\_\_\_  
Patient's Printed Name

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Today's Date

OR

I certify that I am legally entitled to sign on behalf of the patient.

\_\_\_\_\_  
Representative's Printed Name

\_\_\_\_\_  
Rep.'s Signature

\_\_\_\_\_  
Date



# INFINITY SURGICAL ASSOCIATES

4660 Kenmore Ave, Suite 600  
Alexandria, VA 22304

Tel: 703-888-0731  
Fax: 703-888-0791

## PATIENT RESPONSIBILITY WAIVER NON-COVERED PROCEDURES/SURGERY OR NO REFERRAL

I, \_\_\_\_\_ have been made aware

that my insurance company/ies \_\_\_\_\_

(NAME OF INSURANCE COMPANY/IES)

May not cover the following procedures:

1. \_\_\_\_\_ 2. \_\_\_\_\_

3. \_\_\_\_\_ 4. \_\_\_\_\_

I understand that I am and will be financially responsible for all charges/amounts due at the time of service unless other arrangements are made for a payment plan with our office manager and/or billing service.

\_\_\_\_\_  
Patient/ Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Office Personal Signature

\_\_\_\_\_  
Date

### Alternative Arrangements for Payment

Payment for services provided to the patient will be made as follows:

(Describe payment arrangements.)



## INFINITY SURGICAL ASSOCIATES

**PATIENT IS TOTALLY RESPONSIBLE FOR PAYMENT IF SEEN BY PHYSICIAN WITHOUT PROPER REFERRAL. PCP WILL NOT AND CANNOT BACKDATE REFERRALS FOR OFFICE VISITS/PROCEDURES/SURGER**

### Notice of Privacy Practices

As required by the privacy regulations created as a result of the Health Insurance Probability and Accountability Act of 1996(HIPAA). **THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF INFINITY SURGICAL ASSOCIATES) (ISA) MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.**

This Notice describes ISA's privacy practices and those of:

- ☞ Any health care professional authorized to enter information into your ISA chart.
- ☞ All locations of ISA.
- ☞ All employees, staff and other ISA personnel.
- ☞ All of these locations follow the terms of this notice. They may share medical information with each other for treatment, payment or ISA operations purpose described in this notice.
- ☞ Any business associate of ISA that performs services for or on behalf of these entities is required by us to enter into a contact in which it undertakes to accord the same level of confidentiality to medical information that we afford.

### OUR PRIVACY PRACTICES REGARDING MEDICAL INFORMATION

In order to provide you with quality care and to comply with legal requirements, we create a record of the care and services you receive from us. We understand that medical information about you and your health is personal. We are committed to maintaining the confidentiality of medical information about you. This notice applies to all of the records of your care generated by us. We are required by law to:

- Make sure that medical information that identifies you is treated confidentially;
- Give you this Notice of Privacy Practice with respect to medical information about you; and
- Follow the terms of this Notice that is currently in effect.

### HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose medical information. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

☞ **For Treatment.** We may use your medical information to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We may use your medical information in order to write a prescription for you, or we might disclose your medical information to a pharmacy when we order a prescription for you. Many of the people who work for ISA including, but not limited to , our doctors and nurses may use or disclose your medical in order to treat you or to assist others in your treatment. Additionally, we may disclose your medical information to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your medical information to others health care providers for purposes related to your treatment.

☞ **For Payment.** We may use and disclose your medical information in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your medical information to obtain payment from third parties that may be responsible for such costs, such as family members. Also we may use your medical information to bill you directly for services and items. We may disclose your medical information to other health care providers and entities to assist in their billing and collection efforts.



4660 Kenmore Ave, Suite 600  
Alexandria, VA 22304

Tel: 703-888-0731  
Fax: 703-888-0791

## Medical History Questionnaire

Please answer the following questions to the best of your ability; this information is needed so the Doctor will be fully informed of your health history. All information is confidential.

Place an (X) next to what applies to you.

- |  |   |
|--|---|
| 1. Do you have?                              | <input type="checkbox"/> Thyroid Problems |
|  | <input type="checkbox"/> Stroke           |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Asthma           |
| <input type="checkbox"/> Heart Problems      |   |
| <input type="checkbox"/> Diabetes            | Have you ever had?                        |
| <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Rheumatic fever  |
| <input type="checkbox"/> HIV                 |   |
| <input type="checkbox"/> Other _____         |   |
| <input type="checkbox"/> None                |   |

2. If you are allergic to the following place(X) next to it:

- Penicillin
- Iodine
- Codeine
- Betadine
- Latex
- Other \_\_\_\_\_

3. Please list any other Medical problems Or Previous operative interventions

Sign \_\_\_\_\_ Date: \_\_\_\_\_



**Informed Consent of Surgical or Diagnostic Procedures**

**Patient Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

I understand and acknowledge that during the course of my treatment today that the following procedure(s) may be required:

An anoscopy, rigid proctosigmoidoscopy, the banding of a hemorrhoid, the removal of an anal lesion and/or the treatment of the anorectum with possible use of local anesthesia.

Prophylactic treatment with antibiotics.

**I acknowledge and understand that prior to any procedure being performed more specific instructions will be given to me. A diagnosis will be explained and I will have an opportunity to ask questions and have those questions answered. The procedure will proceed only when a verbal informed consent and this written informed consent have been obtained.**

**RISKS**

I understand that the practice of medicine is not an exact science and acknowledge that I have not received any guarantees, assurances, or promises concerning the results of the procedure(s). I understand that as a result of the performance of the procedure(s) there is a moderate risk that I may suffer infection, allergic reaction or loss of blood.

The potential benefits and likelihood of success with treatment are very good. I understand and acknowledge that there are alternatives to treatment such as (but not limited to) invasive surgery, infrared coagulation, over the counter (OTC) medications and not seeking treatment (i.e. living with the condition(s). If the procedure is rejected, the future prognosis is unknown at this time.

I acknowledge and understand that during the course of the procedure(s), conditions may develop which may reasonably necessitate an extension of the original procedure(s) or the performance of procedure(s), which are unforeseen, or not known to be needed at the time this consent is obtained and that my treating physician will not be held responsible for any unforeseen circumstances.

I acknowledge and understand that this request for and consent to surgical and/or diagnostic procedures shall be valid for the responsible physician, all medical personnel under the direct supervision and control of the physician, and for all other medical personnel otherwise involved in the course of treatment.

By signing below, I have read this form and had this form read and/or explained to me and that I fully understand this form, and I have been given ample opportunity to ask questions, and any questions I have asked have been answered or explained in a satisfactory manner. In signing, I understand the relative risks, potential benefits and alternatives for hemorrhoidal therapy and I voluntarily consent to allow Dr. Alshkaki or any physician designated or selected by them and all other personnel that may otherwise be involved in performing such procedures, to perform the procedures described or referred to herein.





**Initial Visit Patient Note**

Today's Date: \_\_\_\_\_ ROS & PFS: See patient intake

**Patient Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Consult** \_\_\_\_\_

**History:**

**Physical Exam**

	WNL	AB	N/E		WNL	AB	N/E		WNL	AB	N/E
General	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal (abdomen)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genitourinary (male)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constitutional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genitourinary (female)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lymphatic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest (breasts)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ears, nose, mouth, throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurologic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>								

**External Exam:** \_\_\_\_\_

**Digital Exam:** Tags Sentinal Pile Ext. Hem's. Spasm Other Lesions Other \_\_\_\_\_

Internal Hemorrhoids RA RP LL Other \_\_\_\_\_ Fissure Location \_\_\_\_\_

**Anoscopy/Proctoscope Exam (circle one):** Procedure Depth: \_\_\_\_\_ Stool in vault:  Descrip. \_\_\_\_\_

Internal Hemorrhoids: RA: G \_\_\_ RP: G \_\_\_ LL: G \_\_\_ Other: \_\_\_\_\_

Fissure: Location \_\_\_\_\_ Polyps: Location \_\_\_\_\_ Masses \_\_\_\_\_ Other: \_\_\_\_\_

Meds Used: NTG Xylocaine Other: \_\_\_\_\_

Procedures: Band: \_\_\_\_\_ I&D Excision of \_\_\_\_\_ Biopsy Other (documentation on page 2)

Meds Rx'ed: NTG NTG+ Diltiazam Lidocaine Lido/Prilo Anusol HC Lotrisone Hydrocortisone

Other Meds: \_\_\_\_\_ OTC Meds: \_\_\_\_\_

Assessment	Plan
<input type="checkbox"/> Int. Hem. <input type="checkbox"/> Ext. Hem <input type="checkbox"/> Anal Fissure <input type="checkbox"/> Pruritis Ani <input type="checkbox"/> Constipation  Other:	<b>Patient provided with:</b> <input type="checkbox"/> Post-band Instr. <input type="checkbox"/> Wound Care Instr. <input type="checkbox"/> Fissure Care Instr. <input type="checkbox"/> Fiber Education <input type="checkbox"/> Prescription Written Other:  F/U _____ Days _____ Weeks _____ Months _____ PRN

**Post-Band Complications:**

- None Substantial Bleeding: (required return visit to office? Yes No)  \*Substantial Pain: (Level:  1  2  3  4)
- Urinary Retention  Sepsis  Stricture  Loss of Work

**(Provider Signature and Date):** \_\_\_\_\_