Colorectal Health Northwest

Providence St. Vincent Medical Center
9155 SW Barnes Rd. Suite 231
Portland, OR 97225

Office 971-254-9884
Fax: 503-206-8365
www.nwcch.com

Scott M. Browning, MD, FACS, FASCRS ☐
Megan M. Cavanaugh, MD, FACS, FASCRS ☐
Jeffrey V. Manchio, MD, FACS, FASCRS ☐
Colon and Rectal Surgeons

HEALTH QUESTIONNAIRE

Patient Name: _____ Date of Birth: _____ Date: _____

Nickname: _____ Home: _____ Cell: _____

Reason for visit: _____

Primary Care Physician Name and Phone:	Referring Physician Name and Phone:

MEDICATION (Please list ALL medications that you are currently taking and their doses. Please include over the counter medications, vitamins and supplements)

Name of Medication	Strength	Name of Medication	Strength

DRUG ALLERGIES: Do you have any allergies to medications? ☐ NO ☐ **YES, please list medications and reactions below**

_____

_____

LOCAL PHARMACY:

Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

PAST MEDICAL HISTORY: (Please list any illnesses or medical problems you have had, and the approximate date of their occurrence)

_____

_____

_____

_____

PAST SURGICAL HISTORY: (Please list all operations you have had and the dates of their occurrence)

_____

_____

_____

PREVIOUS COLON CANCER SCREENING: (Please list the most recent colon screenings you have undergone and the dates of their occurrence)

☐ Flexible Sigmoidoscopy: (Year & Physician) _____ Other: _____

☐ Colonoscopy: (Year & Physician) _____ Did you have polyps? ☐ YES ☐ NO

FAMILY HISTORY (Please list your family member, their age at diagnosis and which side of the family they are on)

☐ Colon or Rectal Cancer: _____ ☐ Colon or Rectal Polyps: _____

☐ Crohn's Disease: _____ ☐ Ulcerative Colitis: _____

SOCIAL HISTORY

What is your marital status? ☐ Single ☐ Married ☐ Widowed ☐ Other _____

Occupation: ☐ Retired ☐ Unemployed ☐ Employed/Job: _____

Employer: _____

Do you have children? ☐ YES ☐ NO **How many?** _____

Would you like a chaperone during your visit? ☐ YES ☐ NO

Do you have any religious objection to blood transfusion? ☐ YES ☐ NO _____

Cigarette smoking status: ☐ Never ☐ Former – Year quit: _____ ☐ Current – Qty per day: _____

Smokeless tobacco use: ☐ Never ☐ Former – Year quit: _____ ☐ Current – Type & Qty: _____

Do you currently use any recreational drugs, including marijuana? ☐ YES ☐ NO Type _____

Do you drink alcohol? ☐ YES ☐ NO Type & drinks/week _____

REVIEW OF SYSTEMS (Do you currently have or have had a history of the following? Please check all that apply)

GENERAL
- ☐ Recurrent fever
- ☐ Significant weight change
- ☐ Sweats
- ☐ Anorexia
- ☐ Fatigue
- ☐ Malaise
- ☐ Sleep disorder

EYES, EARS, NOSE & THROAT
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Eye pain
- ☐ Tinnitus
- ☐ Decreased hearing
- ☐ Nasal congestion
- ☐ Nosebleeds
- ☐ Sore throat
- ☐ Hoarseness

CARDIOVASCULAR
- ☐ Abnormal heart valve
- ☐ High blood pressure
- ☐ Heart murmur
- ☐ Heart attack
- ☐ Peripheral edema
- ☐ High cholesterol
- ☐ Irregular heart beat
- ☐ Pacemaker

RESPIRATORY
- ☐ Wheezing
- ☐ Asthma
- ☐ Shortness of breath
- ☐ Productive cough
- ☐ Sleep apnea/CPAP

ABDOMINAL/GI
- ☐ Hernia
- ☐ Peptic ulcer
- ☐ Difficulty swallowing
- ☐ Reflux
- ☐ Jaundice
- ☐ Vomiting
- ☐ Vomiting blood
- ☐ Gas/bloating
- ☐ Diarrhea
- ☐ Abdominal pain
- ☐ Indigestion/heartburn
- ☐ Constipation
- ☐ Nausea
- ☐ Change in bowel habits
- ☐ Bloody BMs
- ☐ Black BMs
- ☐ Fecal incontinence

UROLOGIC/REPRODUCTIVE
- ☐ Frequent urination
- ☐ Difficulty urinating
- ☐ Blood in urine
- ☐ Urinary incontinence
- ☐ Urinary hesitancy
- ☐ Nocturnal urination
- ☐ Prostate problems
- ☐ Vaginal discharge

MUSCULOSKELETAL
- ☐ Joint swelling
- ☐ Joint pain
- ☐ Arthritis
- ☐ Shoulder pain/hand/wrist
- ☐ Low back pain
- ☐ Muscle weakness
- ☐ Leg pain with exertion

DERMATOLOGIC
- ☐ Rash
- ☐ Itching
- ☐ Hives
- ☐ Skin cancer
- ☐ Non-healing ulcers

NEUROLOGIC
- ☐ Seizure
- ☐ Fainting/blackouts
- ☐ Stroke
- ☐ Paralysis
- ☐ Tremors
- ☐ Frequent headaches
- ☐ Difficulty walking
- ☐ Sciatica
- ☐ Confusion
- ☐ Memory loss

PSYCHIATRIC
- ☐ Depression
- ☐ Anxiety

ENDOCRINE
- ☐ Diabetes
- ☐ Thyroid problems
- ☐ Steroid use

HEMATOLOGIC
- ☐ Bruising
- ☐ Bleeding
- ☐ Blood thinner use

ONCOLOGIC
- ☐ Radiation
- ☐ Chemotherapy

HEIGHT: _____ WEIGHT: _____ BLOOD PRESSURE _____

Patient Signature: _____ **Date:** _____

OFFICE USE ONLY

Entered into EMR by: _____ Date: _____

I have reviewed the above information with the patient on this date.

Physician's Signature: _____ Date: _____

Colorectal Health Northwest

Providence St. Vincent Medical Center
9155 SW Barnes Rd. Suite 231
Portland, OR 97225

Office: 971-254-9884
Fax: 503-206-8365
www.nwcch.com

Scott M. Browning, MD, FACS, FASCRS
Megan M. Cavanaugh, MD, FACS, FASCRS
Jeffrey V. Manchio, MD, FACS, FASCRS
Colon and Rectal Surgeons

PATIENT INFORMATION

Today's Date: _____

Primary Care Physician: _____

Referring Physician: _____

Last Name: _____ First Name: _____ ~~Middle Initial:~~ _____

Date of Birth: ___/___/___ Sex: ☐ M ☐ F Race: _____ ~~Ethnicity~~: _____

Preferred Language: _____ Would you like an interpreter? ☐ YES ☐ NO

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other: _____

Address: _____

City: _____ State: _____ Zip: _____

Home: _____ Cell: _____ Email: _____

Please check where we may leave a detailed message. ☐ Home ☐ Cell ☐ Work ☐ Do not leave detailed message

Emergency Contact: _____ Relationship: _____ Phone: _____

May we speak to your emergency contact regarding your health information? ☐ YES ☐ NO

PRIMARY INSURANCE

Insurance Name: _____

Insurance ID #: _____ **Group or Plan #:** _____ **Network:** _____

Policy Holder/Subscriber Name: _____ Relationship: _____ DOB: _____

Claims Address: _____

SECONDARY INSURANCE

Insurance Name: _____

Insurance ID #: _____ **Group or Plan #:** _____ **Network:** _____

Policy Holder/Subscriber Name: _____ Relationship: _____ DOB: _____

Claims Address: _____

RESPONSIBLE PARTY: (Person responsible for payment) ☐ Self ☐ Spouse ☐ Mother ☐ Father ☐ Other

Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Responsible Party Employer: _____ Work Phone: _____

Address: _____

I understand that I am personally responsible for all charges by my physician, whether or not paid for by insurance, and guarantee payment of the bill. I authorize payment of the medical benefits directly to the physician. I also authorize release of medical or other information to my insurance company.

Signature Required: _____ **Date:** _____

Colorectal Health Northwest

Providence St. Vincent Medical Center
9155 SW Barnes Rd. Suite 231
Portland, OR 97225

Office: 971-254-9884
Fax: 503-206-8365
www.nwcch.com

Scott M. Browning, MD, FACS, FASCRS
Megan M. Cavanaugh, MD, FACS, FASCRS
Jeffrey V. Manchio, MD, FACS, FASCRS
Colon and Rectal Surgeons

General Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks, and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request a physician and/or other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

Oregon law (ORS 441.098) requires us to inform you that:

- You have a choice of where to go when you are referred for a diagnostic test, health care treatment or service.
- When a referral is made, you have to right to talk about your options of where you may go, and the right to choose where you would like to have a test, treatment or service done.
- Your referral will not be denied, limited or withdrawn if you choose another

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____

Signature of Patient or Personal Representative **Date**

_____ _____

Printed Name of Patient or Personal Representative **Relationship to Patient**

Colorectal Health Northwest

Providence St. Vincent Medical Center
9155 SW Barnes Rd. Suite 231
Portland, OR 97225

Office: 971-254-9884
Fax: 503-206-8365
www.nwcch.com

Scott M. Browning, MD, FACS, FASCRS
Megan M. Cavanaugh, MD, FACS, FASCRS
Jeffrey V. Manchio, MD, FACS, FASCRS
Colon and Rectal Surgeons

ACKNOWLEDGMENT AND CONSENT

I understand that Colorectal Health Northwest, LLC (referred to as "This Practice") will use and disclose **health information** about me.

I understand that my **health information** may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnosis, treatments, procedures, prescriptions, and similar types of health related information.

I understand and agree that This Practice may **use and disclose** my health information in order to:

- Make decisions about and plan for my care and treatment;
- Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- Perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be reviewed from time to time and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or summary of the most current version of This Practice's Notice of Privacy Practices in effect will be available in the reception area.

I understand that I have the right to ask that some or all of my information not be used or disclosed in the manner described in the Notice of Privacy Practices, and understand that This Practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I can receive a copy of the Notice of Privacy Practices if I request one.

Patient Signature: _____ Date of Birth: _____ Date: _____

-OR-

Patient Representative Signature: _____ Date: _____

Description of Representative's Authority: _____

Colorectal Health Northwest

Providence St. Vincent Medical Center
9155 SW Barnes Rd. Suite 231
Portland, OR 97225

Office: 971-254-9884
Fax: 503-206-8365
www.nwcch.com

Scott M. Browning, MD, FACS, FASCRS
Megan M. Cavanaugh, MD, FACS, FASCRS
Jeffrey V. Manchio, MD, FACS, FASCRS
Colon and Rectal Surgeons

PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing Colorectal Health Northwest, LLC as your healthcare provider. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

- The patient (or patient's guardian) is ultimately responsible for payment of treatment and care.
- We will bill your insurance for you. However, the patient is required to provide the most correct and updated information regarding insurance.
- Patients are responsible for payment of co-pays, co-insurance, deductibles and all other procedures or treatments not covered by their insurance plan.
- Co-pays are due at the time of service.
- Co-insurance, deductibles and non-covered items are due 30 days from receipt of billing.
- Patients may incur, and are responsible for payment of additional charges, if applicable. These charges may include:
    - $25 charge for returned checks.
    - Charge for missed appointments without 24 hours' notice.
    - $150 deposit to schedule an office appointment if 3 same-day cancellations or 3 no-showed appointments are accrued
    - We reserve the right to keep 25% of the surgery deposit for procedure cancellations with less than 48 hours' notice.

By my signature below, I hereby authorize assignment of financial benefits directly to Colorectal Health Northwest, LLC and any associated healthcare entities for services rendered as allowable under standard third party contracts. I understand that I am financially responsible for charges not covered by this assignment.

I have read, understand, and agree to the provisions of the Patient Financial Responsibility Form.

Signature of patient or guardian

Date

Colorectal Health Northwest

Providence St. Vincent Medical Center
9155 SW Barnes Rd. Suite 231
Portland, OR 97225

Office: 971-254-9884
Fax: 503-206-8365
www.nwcch.com

Scott M. Browning, MD, FACS, FASCRS
Megan M. Cavanaugh, MD, FACS, FASCRS
Jeffrey V. Manchio, MD, FACS, FASCRS
Colon and Rectal Surgeons

Anoscopy Billing Information

Anoscopy or Proctoscopy is often part of a thorough proctologic exam used to identify anorectal problems by allowing the physician to see inside the anal canal and/or rectum. If the doctor does an internal exam in the office, one of these codes will most likely be billed.

These codes are often considered "procedures" by insurance companies; therefore, your insurance carrier may apply the charges to your deductible and co-insurance. This form is to notify you that you may have out of pocket costs associated with this exam that will be billed to you after insurance is billed.

Your signature below does not constitute consent to have this exam done but simply acknowledges that you have been informed and understand the above statements.

We encourage you to contact your insurance carrier to verify your benefits for this exam if you have questions as to what your out of pocket costs will be.

Possible CPT (Procedure) Codes: *Anoscopy - 46600* *Proctoscopy - 45300*

If you are filling out this form as part of the packet we have sent you prior to scheduling your colonoscopy, please note that these codes do not apply to a colonoscopy. We do still ask that you sign below however, acknowledging the above information in case you do need our services for an issue handled in our clinic at a future date.

By signing below I am indicating my acknowledgement and understanding of the above statement.

Signature of patient or guardian _____ Date _____

Print Name _____ Date of Birth _____