THE UNIVERSITY OF TENNESSEE MEDICAL CENTER

UNIVERSITY COLON AND RECTAL SURGERY

University Colon & Rectal Surgery
1934 Alcoa Hwy, Bldg. D, Ste. 370
Knoxville, TN 37920
www.UTColorectal.org
O: (865) 305-5335 Fax: (865) 305-8840

Date: _____

Dear _____:

We would like to welcome you to University Colon & Rectal Surgery. We appreciate the trust you have placed in us.

You are scheduled to see ☐Dr. Mark Casillas; ☐Dr. Andrew Russ; ☐Dr. Gregory Low; ☐Niki Lovelace, NP on _____at _____EST.

☐UT Medical Center Location: 1934 Alcoa Hwy, Bldg D Suite 370
☐UT Halls location: 7326 Maynardville Hwy, Suite 600
☐UT Turkey Creek Location: 11440 Parkside Dr. Suite 301

Please arrive 15 minutes prior to your appointment to allow us to complete your registration. **If you should arrive 15 minutes after your scheduled appointment time above, you will be asked to reschedule.**

Please find the enclosed paperwork needed for your first visit. **It is imperative that you bring the completed paperwork with you to your first visit**. We will require your current insurance card and a driver's license at each visit. We will also require your co-payment at time of your visit. We ask that you prepare for your appointment by **doing a Fleet's enema ONE HOUR prior to leaving for your scheduled appointment time, unless instructed otherwise.**

Patients excluded from Fleet enema include: Colon Cancers above the sigmoid colon, post-operative appointments (unless requested by provider), diverticulitis, colon polyps (rectal polyps need to perform enema), anal fissures, and screening colonoscopies.

We are in Building D Suite 370 on the third floor. The same building as Day Surgery. Parking is available in Parking Garage G, located underneath our building. As you search for a parking space, attempt to park towards Alcoa Hwy and find the elevator underneath our building. Parking costs $3.00 and is paid as you exit the medical center. Enclosed is a map to help you find our building and the correct parking area. You can also download the UTMC Way app to help navigate around the UT Medical Center Campus.

If you have any questions, please call us during business hours Monday-Friday 8:00 AM-4:30 PM.

Thank You,

University Colon & Rectal Surgery

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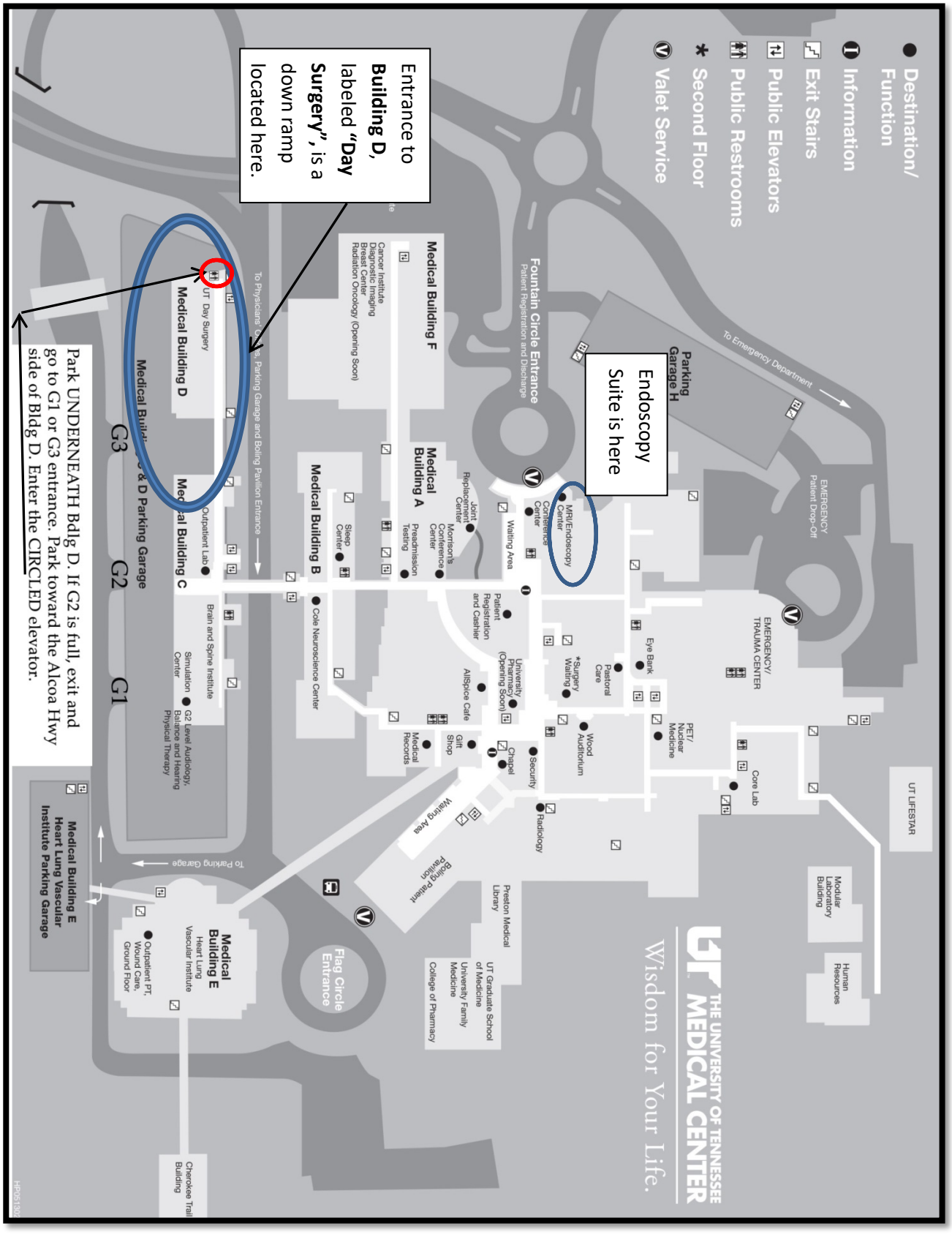

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PATIENT REGISTRATION

Date	For Internal Use Only	Patient Number

PATIENT INFORMATION

Social Security # Date of Birth

First Name Middle Last Name

Home Address City State Zip_____

Email Address Race _____ Ethnicity _____

Gender (circle as many as are appropriate) Birth sex: Male Female Transgender Other
Current sex: Male Female Transgender Other

Marital Status Married Single Home Phone ( )
(Circle One) Divorced Widowed Cell Phone ( )

(Circle One) Employed Retired Disabled Work Phone ( )
F/T Student Other

Employer Referring Physician

How did you hear of us?

PRIMARY INSURANCE INFORMATION

PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST

Insurance ID # GR #

Name of Insured DOB SS#

SECONDARY INSURANCE INFORMATION

Insurance ID# GR #

Name of the Insured DOB SS#

EMERGENCY CONTACT

Relationship

First Name Middle Last

Home Phone ( ) Work Phone ( ) Cell ( )

SPOUSE/GUARANTOR/RESPONSIBLE PARTY

Social Security # Sex Date of Birth:

Relationship Daytime Phone ( )

First Name Middle Last Name

Address City State Zip

Employer Address

City State Zip

AUTHORIZATION TO RELEASE INFORMATION AND PAY BENEFITS TO PHYSICIAN: I hereby authorize the physician to release any information acquired during my treatment necessary to process insurance claims. I also authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services.

SIGNATURE (Patient or Parent if Minor) DATE

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Insurance Payment Policy

Thank you for choosing University Colon & Rectal Surgeons. We are committed to providing you with quality and affordable healthcare. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have developed this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy of this can be provided to you upon request.

1. **Insurance Plans.** We are providers with Medicare, most Aetna plans, Beech Street, Blue Cross/Blue Shield, Blue Care, Champus-military only, Cigna, the Initial Group, Humana, Americhoice Tenncare, United Health and most Medicare Advantage plans. We are **not** in-network providers for UHC Secure Horizon. If you are not insured by a plan, we do business with, payment in full is expected at each visit. If you are insured by a plan, we do business with, but do not have an up to date insurance card, payment in full is required until we are provided with a current copy of your insurance information. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions that you may have regarding your coverage.
2. **Co-payments.** All co-payments must be paid in full at the time of service. This arrangement is part of your contract with your insurance company. Please help us in upholding your agreement by paying your co-payment at each visit.
3. **Non-Covered Services.** Please be aware that some of the services you receive may be non-covered or not considered reasonable or necessary by your insurance, even though your physician feels that it is necessary. Our office will file each visit to your insurance company. If they deem that something is not reasonable or necessary, we ask that you submit payment for that item immediately.
4. **Proof of Insurance.** All patients must complete our patient information form before seeing a physician. We will also ask that you complete this form once a year. We must obtain a copy of your current valid insurance card to provide proof of insurance. If you fail to provide us with the correct information in a timely manner, you may be responsible for the balance of the claim.
5. **Claim submission.** We will submit your claims and assist you in any way we can to help get your claim paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you. If you have Medicare, we will bill you any money's owed after we have received payment from Medicare and/or a secondary policy that you might have.
6. **Coverage Changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. We will also need to have a copy of your new insurance card.
7. **Non-Payment.** If your account is over 90 days past due, you will receive a letter from our billing department. Partial payments are accepted if you call them directly to set up the necessary payment plan. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency.

Our practice is committed to providing the best treatment to our patients. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by all guidelines:

_____ _____

Signature of Patient or Responsible Party **Date**

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(All sections must be completed)

Patient Name: _____ **Date of birth:** _____

SSN: _____ Address: _____

_____

I hereby authorize the release of medical records to University Colon & Rectal Surgeons

Records to be released from: _____

For the following purpose: Medical Treatment

The authorization will expire on: _____
Date or Event may not exceed one year

This request and authorization apply to:

_____ All medical records

_____ Health care information relating to the following treatment,
Condition or dates of treatment: _____

_____

_____ Specific records to be released (eg. Labs, imaging reports, other):

_____

_____

I understand I have a right to revoke this authorization by written notification to the Privacy Officer, except to the extent it has acted in reliance and thereon before notice of revocation. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure which may not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization. I understand that I can refuse to sign this authorization and the above-named office may not condition treatment on my signing of this authorization.

_____ _____

Signature of Patient **Date**

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Patient Name: _____ Date of Birth: _____

I give permission to the physicians and their staff at University Medical Group to leave messages regarding my healthcare in the following manner when I am not available:

Contact Information:

I would prefer to be contacted at: _____Home #_____
_____Cell #_____
_____Work #_____
_____Other #_____

_____May ONLY leave information with me. (If you check here, no other choice should be marked).
_____May leave appointment reminders on my answering machine/voicemail.
_____May leave lab results on my answering machine/voicemail.
_____May leave general questions/information on my answering machine/voicemail.
_____May send confidential messages regarding appointments, lab results, or general messages to your patient portal account
_____May leave a message with a call back number only.

Please list the name of the individual and relationship of anyone we may give information to:
Name: _____ Relationship: _____Phone # _____
Name: _____Relationship: _____Phone # _____
_____May leave appointment reminders with the above listed person
_____May leave lab results with the above listed person
_____May leave general questions/information with the above listed person
_____May discuss billing information with the above listed person
_____I prefer that all healthcare messages be given to the above listed person

If we are unable to reach you by another means, we will send information through the U.S. Postal Service to your home address. We keep a record of each visit. This record may include your test results, diagnosis, medications, and your response to medications or other therapies. This allows your physicians and other clinical staff to provide appropriate care to meet your medical needs. The information in your record is called protected health information. We may disclose your protected health information to other healthcare providers or entities involved in your care.
I understand that my protected health information may be used to coordinate my treatment as described above. I have been offered a copy of the University Health System, Inc. (UHS) Notice of Information Practices. I understand that this Notice describes how my health information may be used or disclosed by this practice, UHS, UHS Ventures Inc., Physicians, and other providers practicing at UHS or UHSV facilities and that I should read it carefully. I am aware that the Notice may be changed at any time.

Signature of Patient_____ Date_____

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UNIVERSITY COLON AND RECTAL SURGERY
PATIENT MEDICAL HISTORY QUESTIONNAIRE

Patient Name: _____Date of Birth: _____Age: _____

Who recommended you to this office? _____ Self-Referral? [ ] Yes [ ] No

HISTORY OF PRESENT ILLNESS:

What is your reason for the office visit today? _____

When did this begin? _____ Have you ever had this problem before? [ ] Yes [ ] No

Has any other physician seen you for this condition? [ ] Yes [ ] No Name: _____

Primary Care Physician (PCP): _____

Address: _____

MEDICAL HISTORY: Please check and/or circle all that apply

[ ] Alcoholism
[ ] Arthritis
[ ] Anxiety/Depression
[ ] Blood Clots _____
[ ] Blood diseases
  [ ] Anemia
  [ ] Leukemia
[ ] Blood pressure – high
[ ] Blood transfusion (date) _____
[ ] Bronchitis
[ ] Cataracts
[ ] Cholesterol-high
[ ] Diabetes (Insulin/Pills)
[ ] Drug addiction
[ ] Epilepsy (Seizures)
[ ] Glaucoma
[ ] Heart Disease
  [ ] Abnormal Rhythm (Fibrillation)
  [ ] Congestive Heart Failure
  [ ] Coronary Disease/Heart Attack
  [ ] Heart Valve Disease
[ ] Kidney disease
  [ ] Kidney stones
  [ ] Dialysis
[ ] Liver Disease
  [ ] Hepatitis
  [ ] Cirrhosis
[ ] Lung Disease
  [ ] Asthma
  [ ] COPD/Emphysema
[ ] Prostate
  [ ] Enlarged (BPH)
  [ ] Cancer
[ ] Psoriasis
[ ] Stroke/Seizures
[ ] Thyroid disease
  [ ] High
  [ ] Low
[ ] Tuberculosis
[ ] Cancer - type (s)
_____
_____
[ ] Osteoporosis
[ ] Parkinson's disease
[ ] Multiple Sclerosis

GI HISTORY:

[ ] Inflammatory Bowel Disease
  [ ] Crohn's disease
  [ ] Ulcerative Colitis
[ ] Irritable Bowel syndrome
[ ] Anal Fissure
[ ] Colon Cancer
[ ] Colon Polyps
[ ] Stomach Disease
  [ ] Reflux/GERD
  [ ] Ulcers
[ ] Rectal Cancer
[ ] Anal Cancer
[ ] Anorectal Abscess
[ ] Anorectal Fistula
[ ] Hemorrhoids

HAVE YOU HAD A COLONOSCOPY? [ ] Yes [ ] No
DATE OF MOST RECENT COLONOSCOPY? _____ **PERFORMED BY?** _____
WHAT WERE YOUR FINDINGS? _____ **ANY POLYPS OR LESIONS?** _____

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DRUG ALLERGIES: [ ] None [ ] List Allergies _____
_____
_____

MEDICATIONS:

Medication	Amount (Dose)	Frequency	Medication	Amount (Dose)	Frequency

PAST PROCEDURE HISTORY: (Year/ Reason/ Complications)

[ ] Colon Surgery _____
[ ] Anal/Rectal Surgery _____
  [ ] hemorrhoids _____
  [ ] fissure _____
  [ ] other _____
[ ] Colonoscopy _____
[ ] Virtual Colonoscopy _____
[ ] Flexible Sigmoidoscopy _____
[ ] Barium Enema _____
[ ] Other Bowel Surgery _____
  What location? _____
[ ] Appendectomy _____
[ ] Gallbladder Procedure _____
[ ] Other Abdominal Surgery _____
  Where? _____
[ ] Hernia repair _____
[ ] Cataract Procedure _____
[ ] Tonsillectomy _____

[ ] Cardiac (heart) Surgery _____
  [ ] Coronary Bypass _____
  [ ] Coronary Stent _____
  [ ] Valve Replacement _____
  [ ] Pacemaker _____
[ ] Lung Procedure _____
[ ] Skin Cancer Surgery _____
[ ] Arthroscopy _____
[ ] Joint Replacement _____
[ ] Prostate Procedure _____
[ ] Hysterectomy _____
[ ] Cesarean Section _____
[ ] D&C _____
[ ] Back Procedure _____
[ ] Neck Procedure _____
[ ] Kidney Procedure _____
[ ] Breast Procedure _____
[ ] Other _____

PREGNANCY HISTORY:

Number of Pregnancies _____
Number of Vaginal Deliveries _____
Number of C-Sections _____
Miscarriage/ Abortion _____

Tears/Episiotomy _____
Age when first pregnant _____
Date of last delivery _____

How many times per week do you have a Bowel Movement? _____
Which laxative(s) do you use? _____
Do you have fecal incontinence? [ ] Yes [ ] No

Do you have fecal smearing? [ ] Yes [ ] No
When did this begin? _____
How frequent are your bowel accidents? _____

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SOCIAL HISTORY:

[ ] Yes [ ] No Have you ever smoked tobacco? How much per day? _____ How many years? _____
When did you quit? _____

[ ] Yes [ ] No Have you ever taken banned substances? What substance? _____

[ ] Yes [ ] No Are you currently taking any over the counter drugs? What drugs? _____

[ ] Yes [ ] No Are you currently taking any herbal drugs? What drugs? _____

[ ] Yes [ ] No Do you consume Alcohol? How many drinks per day/week? _____

[ ] Yes [ ] No Are you currently taking any diet pills? What pills? _____

[ ] Yes [ ] No Are you currently taking any blood thinners? (Aspirin, Ibuprofen, Coumadin, Xarelto, Plavix, Vit. E etc.)

_____

[ ] Yes [ ] No Are you currently employed? What is your profession? _____

[ ] Yes [ ] No Are you married? Other relationship? (NAME) _____

[ ] Yes [ ] No Are you sexually active? What is your sexual Preference? [ ] MEN [ ] WOMEN [ ] BOTH

[ ] Yes [ ] No History of Anal Receptive Intercourse?

FAMILY HISTORY:

Please list any blood relative and their relationship to you that have had any of the following:

Colon polyps: _____ Colon Cancer: _____

Crohn's Disease/Ulcerative Colitis: _____ Rectal Cancer:
_____

Anal Cancer: _____ Other Cancer: _____

Diabetes: _____ High Blood Pressure: _____

Heart Disease: _____ Lung disease: _____

Breast Cancer: _____ Endometrial Cancer: _____

Ovarian Cancer: _____ Gastric/Small Intestine Cancer: _____

Other: _____

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REVIEW OF SYSTEMS: Please circle if positive, or circle [-] if all negative

[-] ***Constitutional:*** Weight loss, # of pounds? _____ Fever Chills Sweats Weakness Fatigue Decreased activity
Over what duration? _____ Other _____

[-] ***Eyes:*** Visual problems Yellowing of eyes Discharge Blurring Double vision Visual Disturbances OTHER _____

[-] ***HEENT:*** Decreased Hearing Ear pain Ringing in Ears Nasal Congestion Sore throat OTHER _____

[-] ***Respiratory:*** Shortness of breath Cough Sputum Production Coughing up Blood Wheezing Apnea OTHER _____

[-] ***Cardiovascular:*** Chest Pain Palpitations Fast/Slow Heart Rate Leg Swelling Passing out OTHER _____

[-] ***Breast:*** Lump/mass Nipple changes Swelling Pain Redness Nipple discharge OTHER _____

[-] ***GI:*** Nausea Vomiting Bloody vomit Diarrhea Constipation Heartburn Incontinence (Stool/liquid/gas)
Abdominal pain: Where? _____ When? _____ Blood in stool: What color? _____ How Frequent? _____
Dark Stool Hemorrhoids Prolapse/Tissue coming out Inability to evacuate Anorectal pain: When? _____
Rectal Pain awakens at night Excessive Mucus with BM Rectal burning/ itching/ discharge OTHER_____

[-] ***Genitourinary:*** Burning/Pain with Urination Blood in urine Change in stream Discharge Lesions/growths
Urinary incontinence OTHER_____

[-] ***Gynecologic:*** Vaginal bulge with BM or Straining Splinting of perineum to evacuate stool Vaginal discharge
Last menstrual cycle _____ Abnormal vaginal bleeding Air per vagina OTHER _____

[-] ***Heme/Lymph:*** Bruising tendency Bleeding tendency Swollen lymph nodes OTHER _____

[-] ***Endocrine:*** Excessive thirst Increased urination Cold intolerance Heat intolerance Excessive Hunger OTHER _____

[-] ***Immunologic:*** Recurrent fevers Recurrent infections OTHER _____

[-] ***Musculoskeletal:*** Back pain Neck pain Joint pain Muscle pain Pain with walking Trauma OTHER _____

[-] ***Skin:*** Jaundice Rash Abrasions Burns Dryness Scarring Lesions/masses OTHER _____

[-] ***Neurologic:*** Headache Confusion Numbness/Tingling Abnormal Balance OTHER _____

[-] ***Psychiatric:*** Anxiety Depression Mania Suicidal Hallucinations Delusions OTHER _____

Other: _____

History of Sexually Transmitted Diseases: [ ] Yes [ ] No What type? _____

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BOWEL CONTROL SATISFACTION SURVEY

Name _____

Which symptoms best describe you?

- Bowel accidents because I am unable to make it to the bathroom in time
- Bowel accidents while asleep/ unaware
- Frequent loose, watery stools
- Abdominal pain

How long have you had these symptoms? _____

Approximately how many bowel accidents do you have per week? _____

Behavior modifications tried_____
(i.e., lifestyle changes, fiber, diet changes, pelvic floor muscle training/biofeedback)

Have you tried medications to help your symptoms?

If yes, check the medications you have tried:

- Imodium
- Iomotil
- Loperamide
- Lomotil
- Diphenoxylate
- Other_____

Did these medications help your symptoms?

If you have stopped taking your meds, explain why:

On a scale of 0 to 10, with 0 being no frustration at all and 10 being extremely frustrated, what is your level of frustration with your bowel control symptoms? _____

Are you interested in learning more about other treatment options?