COLON AND RECTAL SURGERY OF QUEENS

# PATIENT REGISTRATION FORM

## WELCOME TO OUR PRACTICE

*THANK YOU FOR CHOOSING OUR OFFICE! IN ORDER TO SERVE YOU PROPERLY, WE NEED THE FOLLOWING INFORMATION.*

***PLEASE PRINT**. ALL INFORMATION WILL BE CONFIDENTIAL.*

### PATIENT INFORMATION (CONFIDENTIAL)

**NAME**_____ **AGE**_____ **DATE OF BIRTH** _____

**ADDRESS**_____ **SEX**_____ **MARITAL STATUS** _____

**CITY**_____ **STATE**_____ **ZIP**_____ **EMAIL ADDRESS:** _____

**HOME PHONE**_____ **REFERRED BY WHOM** _____

**CELL PHONE** _____ **PRIMARY PHYSICIAN** _____

**SOCIAL SECURITY #**_____ **PERMANENT ADDRESS (IF DIFFERENT)**

**EMPLOYER**_____ **ADDRESS**_____

**ADDRESS** _____ **CITY**_____ **STATE**_____**ZIP**_____

**CITY**_____ **STATE**_____**ZIP**_____ **PHONE#** _____

**WORK PHONE**_____ **OCCUPATION**_____

**PHARMACY NAME & PHONE**_____

**RACE** ☐AFRICAN AMERICAN ☐ASIAN ☐WHITE ☐PACIFIC ISLANDER ☐AMERICAN INDIAN ☐DECLINE

**ETHNICITY** ☐HISPANIC/LATINO ☐NOT HISPANIC/LATINO ☐DECLINE

**INSURANCE INFORMATION-SUBSCRIBER PARTY INFORMATION**

| | | |
|---|---|---|
| **PRIMARY** | **SUBSCRIBER NAME** | **DOB** |
| **GROUP NUMBER** | **IDENTIFICATION NUMBER** | |
| **ADDRESS** | **CITY, STATE ZIP** | **PHONE #** |
| **SECONDARY** | **SUBSCRIBER NAME** | **DOB** |
| **GROUP NUMBER** | **IDENTIFICATION NUMBER** | |
| **ADDRESS** | **CITY, STATE ZIP** | **PHONE #** |

**HOW DID YOU HEAR ABOUT US:** ☐INTERNET-GOOGLE ☐DOCTOR REFERRAL ☐INSURANCE ☐FAMILY/FRIEND ☐OTHER_____

**RESPONSIBLE PARTY INFORMATION (IF DIFFERENT FROM PATIENT)**

**NAME**_____ **BIRTH DATE**_____

**SOCIALSECURITY#**_____ **RELATION TO PATIENT**_____

### PERMISSION FOR VERBAL COMMUNICATIONS

I permit Colon and Rectal Surgery of Queens, PLLC, its physicians, nurses and other personnel to discuss health, medical, and/or billing information, in person or by telephone, with the following individuals listed below. (List individuals and state the person's relationship to the patient):

OR ☐I decline to give a name at this time

Name Phone Number Relationship

1. _____ _____ _____

This document does not permit release of any written health information to the individuals named above. Release of information under this document is limited to verbal discussions only.

**If, at any time, I do not want verbal discussions to be permitted between Colon and Rectal Surgery of Queens, PLLC and any of the individuals named above, I must notify Colon and Rectal Surgery of Queens, PLLC in writing or by calling (718) 475-2017 and speaking with the Practice Office Manager.**

***Signature**_____ **Date**_____

# *Medical History*

**Name**_____ Today's Date_____

**Reason for Today's Visit**_____

**HEALTH QUESTIONNAIRE** Please check the boxes if you have ever been diagnosed with.

| | | | |
|---|---|---|---|
| ☐Alcoholism | ☐Colon Polyps | ☐Glaucoma | ☐Kidney disease/Stone |
| ☐Alzheimer | ☐Crohn's Disease | ☐GERD | ☐Liver disease/Hepatitis |
| ☐Anxiety | ☐COPD | ☐Heart Attack | ☐Mental Illness-specify: |
| ☐Arthritis/Rheumatism | ☐Dementia | ☐Heart Failure | ☐Migraines/Headaches |
| ☐Asthma | ☐Depression | ☐High Blood Pressure | ☐Pneumonia |
| ☐Blood Clots | ☐Diabetes (type1/type 2) | ☐High Cholesterol | ☐Prostate Disease |
| ☐Blood Disorders | ☐Diverticulitis | ☐HIV | ☐Psoriasis |
| ☐Anemia | ☐Eczema | ☐Hypothyroidism | ☐Seizures |
| ☐Bronchitis | ☐Emphysema | ☐Hyperthyroidism | ☐Sickle Cell Disease |
| ☐Cancer-specify: | ☐Fibrocystic Breast Disease | ☐Incontinence(fecal/urinary) | ☐Stroke |
| ☐Cataracts | ☐Fissure | ☐Irregular Heart Beat: specify | ☐Tuberculosis |
| ☐Colitis | ☐Gallstones | ☐Urine Infections | ☐Gastric Ulcers |

## Current Problems?

| | | |
|---|---|---|
| ☐Weight Loss/Gain | ☐Joint Pain | ☐Change in bowels |
| ☐Fever | ☐Joint swelling | ☐Constipation |
| ☐Fatigue | ☐Skin rash | ☐Diarrhea |
| ☐Hearing change | ☐Headaches | ☐Abdominal Pain |
| ☐Nose bleeds | ☐Headaches | ☐Rectal Bleeding |
| ☐Visual change | ☐Insomnia | ☐Dark stools |
| ☐Sore throat | ☐Urinary frequency | ☐Rectal Pain |
| ☐Shortness of breath | ☐Burning with Urination | ☐Rectal Burning |
| ☐Chest Pain | ☐Blood in urine | ☐Rectal Itching |
| ☐Wheezing | ☐Nausea/Vomiting | ☐Fecal Incontinence |

**MEDICATIONS, DOSAGE AND FREQUENCY TAKEN**

***If you have a copy of your list of medications, please give a copy to the front desk.***
***(If more space is needed, please ask the front desk for another form.***

| Medication Name | Dosage (mg) | Frequency |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Medication Allergies and Reactions**: _____

**Type of Allergy**: **Latex** **Iodine** **Contrast**



Please use the back of this form if more space is need.

Name_____

**HEALTH SCREENING**

Have you ever had a mammography? (Indicate date and results) _____

Have you ever had a colonoscopy/flexible sigmoidoscopy? (Indicate date, results & MD)

_____

Have you ever had a prostate screening or PSA level? (Indicate date, results & MD)

_____

| SURGICAL HISTORY | YEAR | OTHER SURGERIES OR PROCEDURES & YEARS |
|---|---|---|
| Appendectomy | | |
| Breast Surgery | | |
| Gall Bladder Removal | | |
| Hernia Repair | | |
| Cardiac Cath | | |
| Heart Stent(s) | | |
| Pacemaker | | |
| Hysterectomy Complete or Partial | | |
| Colon/Small Bowel: Specify | | |
| Anorectal Surgery: Specify | | |

**FAMILY HISTORY**

Colorectal Cancer: Family member affected: _____

Other Cancers in the family:

☐Breast ☐Prostate ☐Stomach ☐Uterine ☐Ovarian ☐Brain ☐Bladder ☐Other_____

☐No Family History of Malignancy

**OTHER FAMILY MEDICAL DISORDERS** Specify: F-Father, M-Mother, B-Brother, S-Sister, D-Daughter, SS-Son

| | | | | |
|---|---|---|---|---|
| Bleeding Problems | _____ | Kidney Disease | _____ | Mother- Alive or Deceased |
| Asthma | _____ | Colonic Polyps | _____ | Cause of death_____ |
| Hypertension | _____ | Diverticulitis disease | _____ | Father- Alive or Deceased |
| Hypercholesterolemia | _____ | Ulcerative Colitis | _____ | Cause of death_____ |
| Diabetes | _____ | Crohn's Disease | _____ | |
| Heart Attack | _____ | Colitis | _____ | |

**SOCIAL HISTORY**

☐Single ☐Married ☐Divorced/Separated ☐Widowed

Work: ☐Yes ☐No ☐Retired Occupation _____

Smoke: ☐Yes ☐No ☐Former Packs/Day_____

Social Drugs: _____

Alcohol: ☐Yes ☐No

☐Monthly ☐Daily ☐Socially

Height: _____ft _____in Weight: _____lbs.

Any Dietary Restrictions: ☐Yes ☐No

Explain: _____

**OBGYN HISTORY**

Pregnancies#_____ Last Pap Smear/Pelvic Exam_____

Children#_____

Deliveries#_____ Vaginal_____ C-section_____

Forceps _____ Episiotomy _____

**Any Falls in the last year? ☐Yes ☐No #____ Injury with fall? ____**

COLON AND RECTAL SURGERY OF QUEENS

# Medical Services Financial Agreement

We, the staff of Colon and Rectal Surgery of Queens PLLC. Thank you for choosing us as your medical provider. We consider it a privilege to serve your colorectal needs and we look forward to doing so professionally, sympathetically and civilly. We are committed to providing you with the highest level of care and to building a successful provider-patient relationship with you and your family.

The performance of a diagnostic procedures and/or treatment may be considered necessary and advisable by the provider at the time of service. You are entitled to a full explanation prior to any testing, procedure, or referral and have the option to decline such treatment or seek further information.

We believe your understanding of our patient service and financial responsibility policy is vital to that provider-patient relationship.

## Insurance

If you have medical insurance, we are eager to help you receive your maximum allowable benefits. In order to achieve this goal, we need your assistance and your understanding of our payment policy.

It is the patient's responsibility to provide our office with all necessary insurance eligibility, identification, authorization, referral information, coordination of benefits or secondary insurance plans. You will be asked to update your personal and insurance information periodically. This includes providing our office with up-to-date copies of your insurance(s) Card(s) and your current address. If you give the wrong insurance information and a referral is required, you will be responsible for the charges.

It is your responsibility to ensure that our providers and practice are in network with your insurance plan prior to services being rendered. We strongly encourage you to contact your insurance plan and verify network status prior to any appointment. Our office staff do their best to know the office insurance contract status. However, insurance plans and networks are always changing, and our staff cannot reasonably be expected to know every insurance plan and network.

We will gladly submit fees for your medical services to your insurance company. However, not all services are a covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover. These non-covered services will then be the patient's responsibility.

If our providers and or practice is Out of Network with your insurance plan or network, you will be responsible for all charges related to and for services rendered. Please remember that your insurance policy is a contract between you and your insurance carrier, and it is your responsibility to understand your benefits/coverage and verify network status.

## Payment for Services

Payment for services, including insurance co-pays, coinsurance, deductibles, non-covered or self-pay balance amounts are due at the time services are rendered unless payment arrangements have been approved in advance by the office staff.

We make payment as convenient as possible by accepting all forms of Credit Cards, Personal Checks and Money Orders.
A $35.00 fee will be charged for all returned checks.

All patient balances will be communicated to the patient in a timely fashion. This will be done via patient paper statements, text message, email and or voice message per the patients elected preference. Patients may also receive paper statements during their office visit or prior to rendering service.

Patient balances must be up to date and paid in full prior to rendering any additional services.
Patients will be sent to collections if balance remains unpaid after 90 days and subject to a $50.00 collection fee.

COLON AND RECTAL SURGERY OF QUEENS

## Surgical Procedures

Our office will verify/ check benefits and obtain any prior authorization should your insurance plan require it prior to any scheduled surgical procedure. Our office will collect our allowed amounts and any patient financial responsibility 7 days prior to the service(s) being rendered. Surgical procedures may be cancelled if payment is not made on or before the 7th day prior to the scheduled procedure date. Patients will be subject to all deductibles, coinsurance copays and non-covered services as indicated by your insurance plan.

There will be a $75.00 fee for surgical procedures cancelled less than 1 week prior to the scheduled procedure date. Cancellation fees must be paid in full before the surgical procedure can be rescheduled. If you are a NO SHOW for your surgical procedure, you will be subject to a $150.00 NO SHOW fee. The provider will need to see you in the office before another date is set. The fee must also be paid in full.

## FMLA/Short Term Disability Forms

There is a $75.00 charge to complete all requests. Payment is due in full prior to the form being completed. Forms will be completed after procedure/surgery and not prior. Additional requests will be charged $75.00. We have 7 business days to complete.

## Missed Appointments/No Show

There will be a $35.00 Charge for missed appointments or no shows. After three no shows you are subject to dismissal from the practice.

I have read, understand and agree to the above financial policy for West Valley Colon & Rectal Surgery Center, LLC.

I authorize the release of any and all medical or other information necessary to determine benefits or the benefits payable for related equipment or services to the organization, the Health Care Financing Administration, my insurance carrier and/or other medical entity. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance company and/or other entity, if requested or required. The original will be kept on file by the organization.

| _____ | _____ | _____ |
|---|---|---|
| Patient/Guardian Signature | Print Name | Date |

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## ALL PATIENTS PLEASE READ AND SIGN

I acknowledge that all of the information supplied on the patient registration form is true and correct and that it has been furnished to this office with full knowledge that the patient is liable for all said services rendered and that he/she is contractually bound to pay for said services, including all costs of collection and a reasonable attorney's fee should collection become necessary. Patient hereby waives his/her confidentiality rights should collection action become necessary.

I hereby authorize Colon and Rectal Surgery of Queens to release any information necessary to file a claim with my insurance company and request that payments under my insurance plans be made directly to Colon and Rectal Surgery of Queens for any services furnished to me. I understand that I am financially responsible for balances not covered by my insurance carrier.

I hereby consent to the administration and performance of all diagnostic procedures and/or treatments which in the judgment of my doctor may be considered necessary and advisable. I am entitled to a full explanation prior to any testing, procedure, or referral and that I have the option to decline such treatment or seek further information.

I also authorize the release of any information required to process insurance claims including any information relating to alcohol abuse, drug abuse, and/or AIDS/HIV.

Self-Pay patients understand that they are financially responsible for all services provided by Colon and Rectal Surgery of Queens. If necessary, I will set up a payment plan with the office manager.

## INFORMED CONSENT

When you become a patient in this office, certain low risk procedures will be performed. As with all medical procedures, there are certain risks involved. Anoscopy, proctoscopy, flexible sigmoidoscopy, polypectomy, hemorrhoidal ligation, drainage of abscess and laser surgery are all low-risk procedures often performed in this office. These will all be explained to you in consultation before your examination. If you have questions at any time about what is being done to you, please ask the doctor or office personnel immediately.

Patient Signature: _____ Date: _____

## Anoscopy Notice

Your provider may perform an Anoscopy procedure as part of your evaluation, this may be necessary to obtain a diagnosis and for treatment purposes. This will be billed to your insurance; however, Insurance plans consider this a surgical procedure it is a separate fee from the office visit and the Insurance may apply this fee towards your deductible/coinsurance so you may be responsible for an additional amount after the claim is processed.

An Anoscopy is a simple procedure where a small instrument (anoscope) is inserted into the rectum. This allows your provider to identify any abnormalities in the anorectal area. The procedure is very brief, with minimal discomfort. Your provider will review this further with you if this needs to be performed.

Patient Name: _____ Patient DOB: _____

Patient Signature: _____ Date: _____