COMMUNICATION OF PATIENT INFORMATION

To all of our patients:

Please inform us if information regarding your treatment or results may be discussed with:

SPOUSE	YES	NO
CHILDREN	YES	NO
ONLY SELF	YES	NO
OTHER:	_____	

Please inform us if information regarding your treatment or results may be left on your answering machine of cell phone:

Answering machine:	YES	NO
Cell Phone:	YES	NO

Please be advised that messages regarding appointments may be left on an answering machine.

Signature: _____

Date: _____

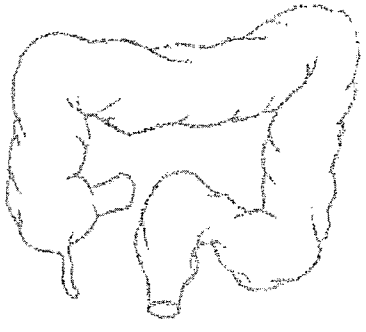
PLEASE FILL OUT **ALL** PAGES, THANK YOU!

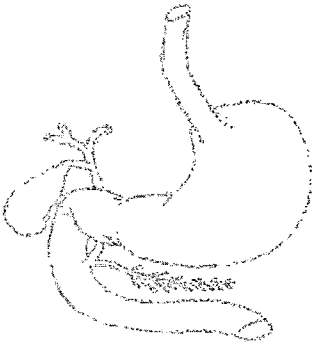
Gastrointestinal Associates of Rockland

DIPLOMATES AMERICAN BOARD OF GASTROENTEROLOGY

500 New Hempstead Road Suite A
New City, NY 10956
845-362-3200
Fax: 845-290-8180
www.gastrorockland.com

LOUIS D. MAY, M.D.
SHARON MOLINAS, M.D.
STEPHEN GOODMAN, M.D.
WINSON LO, M.D.
JOSHUA OLSTEIN, M.D.
Kenneth M. Banner, M.D.





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Patient name: _____.

Assignment and Release:
I hereby certify that (or my dependent) have insurance coverage with (Name of Insurance Company) _____, and assign directly to GI Associates of Rockland all payments for medical services rendered. I hereby authorize release of all information necessary to secure the payment of benefits. I accept financial responsibility for co-payments, deductibles, medical care and other provided services which are not specifically covered by my insurance plan, or not covered due to the absence of authorizations/referrals that I am obligated to obtain under my contract. This agreement is not intended to conflict with or circumvent the provisions of any contracts or regulations that may be governed by applicable contracts or government regulations. I authorize the release of relevant medical information to those healthcare providers involved in my care and treatment.

Signature: _____ Date: _____

Medicare Patients Only:

I certify that the information given by me in applying for payments under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and Healthcare Financing Administration or its intermediaries or carriers, any information needed for this or any related medical claim. I request that payment of authorized benefits be made on my behalf. I assign benefits payable to the physician(s) providing services. I authorize the release of relevant medical information to those healthcare providers involved in my care and treatment.

Signature: _____ Date: _____

*****Reasonable attorney and/or collection fees will be added if we deem it necessary to refer this account for collection ********

GASTROINTESTINAL ASSOCIATES OF ROCKLAND

ABOUT YOUR INSURANCE BENEFITS

In the past few years, the number of different health insurance programs has increased at an amazing rate. Even within one company, there may be several programs with varying benefits and requirements. Therefore, it is the responsibility of the patient to know the specific benefits and requirements of their plan.

- Some programs require that a specific facility be used for your blood tests, x-rays or ultrasounds.
- Some programs require pre-authorization while others do not.
- Some insurance companies require PATIENTS to notify them of hospital admissions or trips to the emergency room.
- Some insurance companies require referrals from your primary care physician.
- Some programs only pay a percentage of our charges, even "in-network", causing a potentially large expense to the patient.
- Our pathology lab is considered out of network, therefore payments from your insurance company may go directly to you and you will be responsible for forwarding the payment to this office.

It is **YOUR RESPONSIBILITY** to know and to advise us of your program's requirements in advance each and every time we schedule an appointment or provide a service to you. Please understand that if we have not been advised in advance of your program's requirements or conditions and we provide a service or use a laboratory that is outside of your program requirements, **you will be responsible for the appropriate fees.**

Always check with your insurance company before having any tests done to ensure that the place of service you are going to accepts the insurance and that the test or tests you are having done are covered by your insurance company.

There will be a $50.00 service fee if 48 hour cancellation notice is not given for any procedure appointments!!

I UNDERSTAND AND ACKNOWLEDGE RECEIPT OF THE ORIGINAL COPY OF THIS INFORMATION.

_____. _____.

Signature Date

_____.

Please print your name

8/2010

GASTROINTESTINAL ASSOCIATES OF ROCKLAND
PATIENT INFORMATION FORM

Patient Name:	**M F Age:**
	Date of Birth:
Street Address	**SS#**
	Home Phone:
City, State, Zip:	
	Work Phone:
Race: **Ethnicity**	
Language:	**Cell Phone:**
	E-mail:

Primary Insurance	
ID# **Group#**	
Policy Holder Name if Different from Above:	**Policy Holder Employer:**
Policy Holder Date of Birth:	**Policy Holder SS#**
Policy Holder Relation to Patient:	**Policy Holder Employer:**
Secondary Insurance:	
ID# **Group#**	**Policy Holder SS#**
Policy Holder Name if Different from Above:	**Policy Holder Date of Birth:**

Responsible Party's Name (Last, First, Middle)	**M F Legal Representative Y N**
Responsible Party's Address	**Relationship to Patient?** **Spouse Parent Guardian**
City **State** **Zip**	**Other:**_____
Phone:	

Primary Care Physician: **Cardiologist:**
Any other physician you would like your reports sent to?
Preferred Pharmacy:

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a precentage of the charge. It is your responsibility to pay any deductable amount, coinsurance or any other balance not paid for by your insurance.
If your insurance requires a written referral from your physician and you do not obtain one prior to your visit or procedure, you will be responsible for payment for services rendered.
COPAYMENTS ARE EXPECTED AT THE TIME SERVICES ARE RENDERED.

If this account is assigned to any attorney of collection and/or suit, the practice shall be entitled to reasonable attorney's fees and costs of collection. I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled including Medicare, private insurance and third party plans to the practice named on this form.
I AGREE TO THE ASSIGNMENT AND FINANCIAL RESPONSIBILITIES SHOWN ON THIS PAGE.

Signature of Patient/Responsibility Party **Date**
Type of photo ID presented (if license check)_____. No Photo ID Available_____.

Please fill-in all sections. If something does not apply please write N/A.
Primary Care Physician and Pharmacy are required. Thank you!

PATIENT MEDICAL HISTORY INFORMATION

Patient Name: Weight Height

Are you currently taking Aspirin No Yes (If yes, how often)

Are you currently on Coumadin/Warfarin or Plavix? No Yes

Do you have any allergies to medications No Yes (If yes, please list below)

Please list any medications you are currently taking and the reason they are prescribed:

Please list any prior surgery you may have had:

Have you had COVID-19 No Yes If Yes, hospitalized? No Yes Date:

Vaccinated for Covid 19 No Yes Boosted: No Yes

Do you have:

- Digestive Diseases No Yes
- A History of Kidney Stones No Yes
- Blood Clotting Problems No Yes
- A Family History of Colon Cancer No Yes
- A Family History of Digestive Diseases No Yes

Do you smoke? No Yes (If yes, how much)

Do you drink alcohol No Yes (If yes, how frequently)

Are you pregnant? No Yes (Start date of last period)

Signature of Patient/Responsible Party Date:

THIS IS IN COMPLIANCE WITH REGULATIONS WHICH GOVERN ALL INSURANCE COMPANIES

Alcohol:

Did you have a drink containing alcohol in past year?

YES or NO

If yes, please answer the following questions,

How often did you have 6 or more drinks on one occasion in the past year?

A. Never (0 points)
B. Less than monthly (1 point)
C. Monthly (2 points)
D. Weekly (3 points)
E. Daily or almost daily (4points)

How often did you have a drink containing alcohol in the past year?

A. Never (0 points)
B. Monthly or less (1 points)
C. 2 to 4 times a month (2 points)
D. 2 to 3 times a week (3 points)
E. 4 or more times a week (4 points)
F. 6 or more times a week (4 points)

How many drinks did you have on a typical day when you were drinking in the past year?

A. 1 or 2 drinks (0 points)
B. 1 to 2 drinks (0 points)
C. 3 or 4 drinks (1 points)
D. 5 or 6 drinks (2 points)
E. 7 to 9 drinks (3 points)
F. 10 or more drinks (4points)

Have you used drugs other than those for medical reasons in the past 12 months?

YES or NO

Have you ever had a blood transfusion?

If YES, what year? _____ or NO

Sexual history

Have you ever had a sexual transmitted infection?

YES or NO

Last menstrual period Date:_____

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AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION

(To be used for requesting records that will be sent to GI Associates of Rockland

I, _____, Date of Birth: _____authorize my physician- (enter name) _____ to use and/or disclose my health information to: GI Associates of Rockland, PC, for the following purpose(s):

_____.

By initialing the spaces below, I specifically authorize the use or disclosure of the following health information and/or records, if such information and/or records exist:

_____ Please send the entire medical record (all information). _____Colonoscopy/Pathology reports only

_____ Clinician office chart notes _____ Transcribed hospital reports _____ Laboratory or imaging reports

_____ Medical records needed for continuity of care ____ Most recent 5-year history (summation) _____Other

*** The following items must be initialed to be included in the use or disclosure of other health information:**

_____ *HIV/AIDS related health information and/or records _____ *Mental health information and/or records

_____ *Genetic testing information and/or records _____ *Drug/alcohol diagnosis, treatment, and/or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed. Federal law prohibits the re-disclosure of such information.) _____

Except to the extent that action has already been taken in reliance upon this authorization, I understand that I may revoke this authorization at any time by giving written notice to GI Associates of Rockland, PC. Unless revoked earlier, this authorization will expire 180 days from the date of signing. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment, or eligibility for benefits. I may inspect or copy any information to be used or disclosed under this authorization. I also understand that, if the entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations.

_____ _____

Signature of Individual or Individual's Legal Representative Date

_____ _____

Print Name of Legal Representative (if applicable) Relationship of Legal Representative to Individual

(A copy of this signed form will be provided to the individual and/or the individual's legal representative)