

COLON RECTAL SURGICAL ASSOCIATES, LLC

PATIENT REGISTRATION

WELCOME TO OUR PRACTICE!

ACCOUNT # _____

LAST NAME _____ FIRST NAME _____ MIDDLE INITIAL _____

HOME ADDRESS _____ ZIP _____

SEX ___M___F HOME PHONE _____ WORK PHONE _____ BIRTH DATE _____

SOCIAL SECURITY # _____ MARITAL STATUS ___S___M___W___D

EMPLOYER _____ EMPLOYER'S ADDRESS _____

NEXT of KIN, SPOUSE, &/or RESPONSIBLE PARTY _____ PHONE _____

REFERRING PHYSICIAN _____ PRIMARY CARE PHYSICIAN _____

PRIMARY INSURANCE CO _____ GROUP # _____ ID # _____

INS CO ADDRESS _____ PHONE # _____

POLICY HOLDER'S NAME _____ POLICY HOLDER BIRTH DATE _____

ADDRESS _____ CITY/STATE _____ ZIP CODE _____

PHONE # _____ RELATIONSHIP TO PATIENT ___SELF___ PARENT ___SPOUSE___ OTHER

POLICY HOLDER'S EMPLOYER _____ EMPLOYER'S PHONE # _____

SECONDARY INSURANCE CO _____ GROUP # _____ ID # _____

INS CO ADDRESS _____ PHONE # _____

POLICY HOLDER'S NAME _____ POLICY HOLDER BIRTH DATE _____

ADDRESS _____ CITY/STATE _____ ZIP CODE _____

PHONE # _____ RELATIONSHIP TO PATIENT ___SELF___ PARENT ___SPOUSE___ OTHER

POLICY HOLDER'S EMPLOYER _____ EMPLOYER'S PHONE # _____

I recognize and agree that I am responsible for payment of all medical services provided for me or my legal dependent by Drs. Berg/Vachon/Zalucki/Cifello/Somerville/Akbari, regardless of my insurance coverage, and that payment is due within thirty (30) days of the date payment is requested. I agree that in the event that my account must be turned over for collection, I will be responsible for collection fees, attorney fees, court costs and interest.

I hereby authorize Colon Rectal Surgical Associates, LLC to apply for benefits for any covered services rendered and I request the direct payment of authorized medical benefits (including Medicare, Medigap, Major medical benefits) be made to **Colon Rectal Surgical Associates, LLC** for any services furnished by these physicians. I authorize any holder of medical information about me to release this information to my insurance carrier (or intermediaries), to the Health Care Financing Administration and its agents, to my attorney, or to another physician's office.

I permit a copy of this authorization to be used in place of the original copy. This agreement will remain in effect until I revoke in writing, this authorization.

SIGNATURE

SEAL

DATE

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our payment policy.

There are hundreds of different insurance policies and managed care options. Please appreciate the complexity of insurance coverage today. It is impossible to obtain payment for services without having the full cooperation of the patient. We are experts in colon and rectal care, not insurance. We will help you if we can; however, it is ultimately your responsibility to know your insurance policy.

Does your insurance require a referral from your primary care physician? Have you obtained that referral? The referral must be received by the time of your visit or you will be required to pay for the service. Many managed care plans do not issue referral numbers after the date of service. Look at your insurance card. A toll free number is usually listed on the back of the card. Someone with your insurance company should be able to answer your questions.

We must emphasize that as medical care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Returned checks and balances older than thirty (30) days may be subject to additional collection fees and interest charges of 1.5% per month. Charges may also be made for broken appointments and appointments cancelled without 24 hours advanced notice.

If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE don't hesitate to ask us. We are here to help you.

- I hereby understand that I am responsible for giving "Colon Rectal Surgical Associates, LLC" the correct insurance information.
- I am also responsible for obtaining the proper referral.
- I agree to pay for services for which I failed to obtain a proper referral.
- I agree to pay for non-covered services under my insurance plan.
- I have read, understand and agree to the above information.

Signature: _____ SEAL

Date: _____

PATIENT MEDICAL INFORMATION FORM

Name: _____ Referring Doctor: _____ Age: _____

Chief reason for doctor visit: _____

How long have you had this problem: ___ Days ___ Months ___ Years

Please check all that apply:

1. Rectal Bleeding ___; at time of BM ___; not related to BM ___
2. Blood: bright ___; dark ___; on paper ___; in water ___; mixed in stool ___; clots ___
3. Pain at BM ___; itching ___; burning ___
4. New onset of constipation ___; how long _____
5. New onset of diarrhea ___; how long _____
6. Abdominal pain ___;
location (upper or lower abdomen, right or left side) _____; how often _____
7. Change in bowel habits ___; explain _____

8. Leakage of stool ___; explain _____
Can you hold gas: yes / no . If you have incontinence, how often _____
9. Change in size of stool: smaller ___; larger ___
10. Nausea ___; vomiting ___; fevers ___;
weight loss ___; how much _____; over how long a period of time _____
11. Family history of Ulcerative Colitis ___; Crohn's Disease ___; Colon Polyps ___;
relationship _____
colon or rectal cancer ___; relationship _____

Please circle all that apply:

12. **Heart Problems:** chest pain; irregular heart beat; murmur; other _____
 13. **Lung Problems:** Asthma; Emphysema; shortness of breath; other _____
 14. **Kidney/Bladder Problems:** incontinence; hesitancy; frequency
 15. **Other medical problems:** High Blood Pressure; Diabetes; Thyroid Problems; Arthritis;
Hepatitis (type/when) _____; HIV; Elevated Cholesterol;
other _____
 16. **Medications** (name, dosage and frequency – use other side if necessary)

 17. **Allergies to Medications** _____

 18. Previous Surgeries _____

 19. Cigarette smoking _____ pack/day; Alcohol _____ day or week; Drug usage _____
- Reviewed by: (Physician initials/date) _____

PLEASE BRING YOUR REFERRAL AND INSURANCE CARD WITH YOU.

COLON RECTAL SURGICAL ASSOCIATES, LLC

**PRIVACY POLICIES
EFFECTIVE 4/14/2003**

We are required by law to protect the privacy of your health information. This notice describes how medical information about you may be used and disclosed and how you can gain access to that information. Please read the document carefully and sign the bottom to acknowledge that you have received it.

The general consent for release of medical records that you sign authorizes Colon Rectal Surgical Associates to disclose the information in your medical record for treatment, payment and health care operations. Your information may be shared with: employees and contractors of this practice, with other health care providers who are treating you or consulting in your care, with your insurance company or other third party payors responsible for authorizing or paying for all or part of your care, and with our billing service to facilitate billing operations. We may be required by law to disclose records that you have not authorized such as when we receive a subpoena or for public health reasons. This information may be communicated in the following ways: mail, fax, Internet, phone/voice mail and personal communication.

We may need to contact you by phone to discuss appointments, test results, treatments, referrals, account balances or to return your phone call. We will attempt to contact you at home, but if necessary and if you have provided us with an alternate phone number, we will attempt to contact you at that number. If you are not available, we will leave a message for you to return the call, or to remind you of your appointment or the need for a referral. We will send statements or reminder notices to the home address that you provide us with at the time you registered with the practice. We may disclose your protected health information to your family or other individuals identified by you when they are involved in your care or the payment for your care.

If you would like information sent to another physician or medical facility, or if you would like us to release information to a life or disability insurer, you must authorize the release of this information in writing.

You have a right to inspect and/or obtain a copy of your medical record. You may request changes to be made to your medical records. You must make this request in writing with reasons that support your request. We will review your request and if we do not agree with the changes, you are entitled to have your statement added to your medical record. We must maintain a log of disclosures made by us except for disclosures made for treatment, payment and health care operations and you have a right to request a copy of this log.

We trust that you are comfortable with our sincere efforts to maintain the confidentiality of your medical record. If you believe that your rights have been violated, you may contact our Practice Administrator by phone (410-363-6664) or by mail (c/o Colon Rectal Surgical Associates, 25 Crossroads Dr, Suite 312, Owings Mills MD 21117); or you may complain to the Secretary of the US Dept. of Health & Human Services. There will be no retaliation for making a complaint.

We reserve the right to change our privacy practices and to make new policies for protecting the health information of our patients. If we do so, we will issue an updated copy of the privacy policies to all of our patients. You may revoke any consent/authorization provided to us by giving written notice.

I, _____ acknowledge receipt of this privacy policy.

Signature* SEAL

Date

* I HAVE BEEN GIVEN THE OPPORTUNITY TO READ AND OBTAIN A COPY OF THE FULL DETAILED PRIVACY NOTICE.

IMPORTANT NOTICE TO ALL PATIENTS

Colon Rectal Surgical Associates has implemented the following policies and fees to better control rising costs.

ALL office co-pays must be paid at the time of service, when you check in at the front desk. We accept cash, check and credit card (VISA and Mastercard). If you do not have your copay, we will reschedule your appointment.

The insurance company holds the patient responsible for having a valid referral at the time of service. We can retrieve an electronic referral, however if the referral is a paper referral, it is the patient's responsibility to be sure that we have it at the time of service. You may bring the referral with you or if your physician's office faxes referrals, you must make sure that it has been faxed and is in our office at least one day prior to your appointment. If the referral is not available when you arrive for your appointment, you may reschedule the appointment or you may request that we obtain the referral for you. The fee for this service will be \$10.00 payable at the time you check in.

There is a \$10.00 fee for completing disability/FMLA/insurance forms, etc. This amount should be paid when the form is mailed or brought into the office to be completed.

Patients who do not show up for a scheduled office appointment and do not call to cancel that appointment will be charged a \$20.00 fee.