SUBURBAN GASTROENTEROLOGY

DINESH JAIN, M.D.
SCOTT BERGER, M.D.
SUSHAMA GUNDLAPALLI, M.D.
DARREN KASTIN, MD
RAVI NADIMPALLI, M.D.
CHRISTOPHER BOUTIN, M.D.

1243 Rickert Dr.
Naperville, IL 60540

Telephone 630-527-6450
Fax 630-527-6456

Suburban Gastroenterology, Ltd. would like to welcome you and confirm your appointment.

DAY: ____________________________

DATE: ___________________________

TIME: ___________________________

PLACE: **Suburban Gastroenterology**
1243 Rickert Dr.
Naperville, IL 60540

Enclosed is a map for your information regarding location.

Please bring with you a list of current medications you are taking and any records or tests that pertain to the reason you are seeing the physician: i.e. upper GI x-rays, any recent blood work, Ultrasounds, or CT scans. We will also need you to bring your insurance card. If your insurance is an HMO, POS, EPO or managed care plan, please remember your authorization number or referral. All copays, deductibles and non-insured patients will be expected to make payment at the time of service.

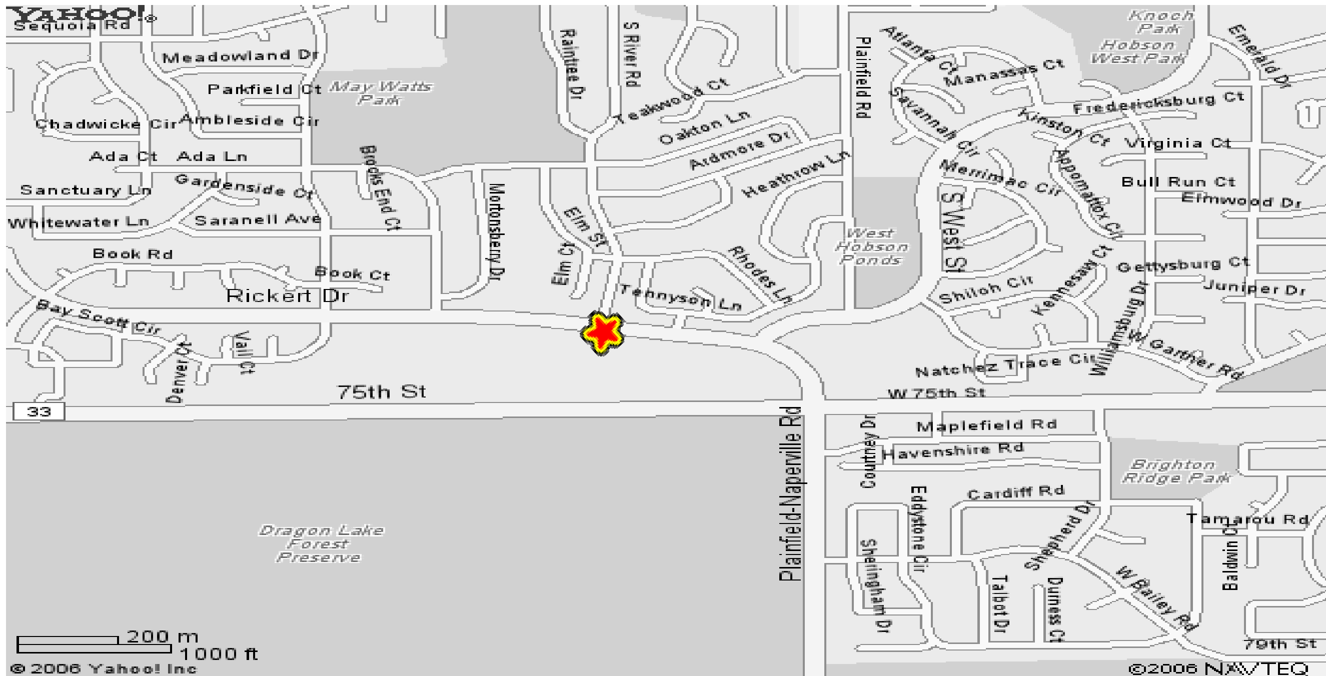
We ask that you complete the enclosed registration form, patient questionnaire, and sign where indicated. Please bring these forms with you on your appointment date.

Because of the number of patients waiting to receive medical care, we need to insure that all available appointments are used. In the event that you are unable to keep your appointment, please notify us at (630) 527-6450 within two working days so that we may offer your time to another patient.

Thank you for choosing Suburban Gastroenterology, Ltd. We look forward to serving your patient care needs.

* If the enclosed packet is not completed and brought with you on the day of your appointment, we request that you arrive 15 minutes early. As a courtesy to other patients, if you can not arrive on time, you may have to be rescheduled.

Suburban Gastroenterology and Midwest Endoscopy



1243 Rickert Drive
Naperville, IL 60540
Phone: (630) 527-6450

<u>From the North</u>
I-355 South
Exit 75th Street
Turn Right (heading West) on 75th Street to
Rickert Drive (same road as Plainfield/Naperville Road)
Turn Right at stoplight for Rickert Drive
Turn Left at side street – River Road

<u>From the South</u>
Rt. 53 North
Turn Left (heading West) on 75th Street to
Rickert Drive (same road as Plainfield/Naperville Road)
Turn Right at stoplight for Rickert Drive
Turn Left at side street – River Road

<u>From the East</u>
Ogden Ave (Rt. 34) West
Turn Left on Rickert Drive
Turn Right on side street – River Road

<u>From the West</u>
I-88 East
Exit Rt. 59 Turn Right (South)
Take Rt. 59 to Ogden Ave. (Rt. 34)
Turn Left on Ogden Ave (Rt. 34) to Rickert Drive
Turn Right on Rickert Drive
Turn Right on side street – River Road

*** PLEASE PRINT ***

PATIENT REGISTRATION

PATIENT NAME____ DOB____________AGE_________ MALE FEMALE
FIRST INITIAL LAST

PATIENT SOCIAL SECURITY# ______________________________ PHONE (HOME) ______________________________________ MARITAL STATUS
S M W D

PHONE (WORK) ____ PHONE (CELL) _______________________________________

PATIENT ADDRESS ____
STREET CITY STATE ZIP COUNTY

PATIENT EMAIL ADDRESS _________________________ Can we use your e-mail to send results and correspondence? Yes _______ No _______

PATIENT PRIMARY CARE PHYSICIAN _______________________________ PATIENT REFERRING PHYSICIAN _______________________________

PATIENT'S EMPLOYER ____

EMPLOYER ADDRESS ____ EMPLOYER PHONE # ______________________

EMERGENCY CONTACT ____RELATIONSHIP _____________________________

EMERGENCY CONTACT PHONE (HOME) ______________________________ EMERGENCY CONTACT (WORK) ______________________________

DO YOU HAVE ADVANCED DIRECTIVES (i.e. living will): ____

INSURANCE INFORMATION: (NEEDED IN ORDER TO FILE YOUR CLAIM)

PRIMARY INSURANCE COMPANY ____

IDENTIFICATION NUMBER ____GROUP NUMBER ____

____
ADDRESS OF INSURANCE COMPANY CITY STATE ZIP

POLICY HOLDER NAME (if other than patient) ____RELATIONSHIP ______________________

POLICY HOLDER DOB ________________________________ POLICY HOLDER SOCIAL SECURITY NUMBER ________________________________

POLICY HOLDER PLACE OF RETIREMENT ____

SECONDARY INSURANCE COMPANY ____

IDENTIFICATION NUMBER ____GROUP NUMBER ____

____
ADDRESS OF INSURANCE COMPANY CITY STATE ZIP

POLICY HOLDER NAME (if other than patient) ____RELATIONSHIP ______________________

POLICY HOLDER DOB ________________________________ POLICY HOLDER SOCIAL SECURITY NUMBER ________________________________

POLICY HOLDER PLACE OF RETIREMENT ____

PATIENT'S AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND CLAIM PAYMENT AUTHORIZATION; I HEREBYAUTHORIZE THE ABOVE PHYSICIAN(S) TO RELEASE ANY INFORMATION REGARDING SERVICES RENDEDRED BY THE PHYSICIAN AND ALLOW A PHOTOCOPY OF MY SIGNATURE TO BE USED TO FILE INSURANCE. I ALSO HEREBY AUTHORIZE AND DIRECT MY INSURER TO ISSUE PAYMENT CHECK (S) FOR BENEFITS DUE ME FOR THE SERVICES RENDERED BY THE ABOVE NAMED PHYSICIAN(S) TO BE MADE DIRECTLY TO THE PHYSICIAN REGARDLESS OF MY INSURANCE BENEFITS, IF ANY. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR THE FEES FOR SERVICES RENDERED.

____
DATE PATIENT (PARENT OR GUARDIAN IF MINOR)

STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER, PHYSICIAN AND PATIENT; I CERTIFY THAT THE INFORMATION GIVEN BY ME IN APPLYING FOR PAYMENT UNDER TITLE XVIII OF THE SOCIAL SECURITY ACT IS CORRECT. I AUTHORIZE MY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION OR ITS INTERMEDIARIES OR CARRIERS ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE CLAIM. I REQUEST THE PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF. I ASSIGN THE BENEFITS PAYABLE FOR PHYSICIAN SERVICES TO THE PHYSICIAN OR ORGANIZATION FURNISHING THE SERVICE OR AUTHORIZE SUCH PHYSICIAN OR ORGANIZATION TO SUBMIT A CLAIM TO MEDICARE FOR PAYMENT TO ME. I REQUEST THAT PAYMENT UNDER THE MEDICAL INSURANCE PROGRAM BE MADE EITHER TO ME OR TO THE ABOVE NAMED PHYSICIAN(S).

____
DATE PATIENT (PARENT OR GUARDIAN IF MINOR)

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ADDITIONAL DEMOGRAPHIC INFORMATION

NAME ___________________________________ DOB _____________ DATE ____________

RACE:

American Indian or Alaskan Native
Asian
Black or African American
Native Hawaiian or Pacific Islander
White
Unknown
Refuse to disclose
Other ________________________________

ETHNICITY:

Hispanic or Latino
Non Hispanic or Latino Ethnicity
Unknown
Refuse to disclose

REFERRED BY:

Primary Care Physician
Patient Referral
Yellow Pages
Emergency Room
Insurance Plan
Former Patient
Relative
Friend
Edward Referral
Other

HIPAA PERMISSION FOR RELEASE OF INFORMATION

In order to comply with specific rules regarding HIPAA (Health Insurance Portability & Accountability Act of 1996, we ask that our patients complete and sign this privacy and security of health information document.

Patient Name: ___________________________________ Date: _______________________

Personal Representative: ___________________________ Relationship: __________________

It is the office policy of Suburban Gastroenterology, LLC not to release confidential and/or unauthorized information by home telephone, answering machine, e-mail, telephone, voicemail, or cell phone. Whenever returning telephone calls and the answering machine picks up we cannot leave a message if the name and telephone number is not on the recorded message to identify the residence. Information will also not be left with an unauthorized person who may answer the telephone.

I authorize Suburban Gastroenterology, LLC and staff to leave medical information pertaining to my care by the following methods and will assume responsibility of notifying Suburban Gastroenterology, LLC whenever this information changes.

Home Telephone _____YES _____NO
Answering Machine _____YES _____NO
Work Telephone, Number _____________________ _____YES _____NO
Voicemail: _____YES _____NO
Cell phone/Voicemail # _______________________ _____YES _____NO
Work Fax Number ___________________________ _____YES _____NO
Home Fax Number ___________________________ _____YES _____NO
Email, address: ______________________________ _____YES _____NO

Patient must sign appropriate release of information before health information will be sent to the following:
Other Physician Office _____YES _____NO
Insurance Company _____YES _____NO

If you would like the information released to someone other than yourself, please complete the following:
Please list names of people authorized to receive your health information other than yourself:
Spouse - Name: _______________________________________
Parent - Name: _______________________________________
Other - Name: _______________________________________

Date: ________________ Patient/Guardian Signature: _______________________________

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Insurance and Billing Policy

1. Suburban GI will submit claims to your insurance carrier for services provided by our physicians. These include office visits, consultations and surgical procedures. Surgical procedures (colonoscopies, gastroscopies and flexible sigmoidoscopies) are billed as "out-patient surgery".

   Unless otherwise requested, all biopsies performed in our facility and all second opinions will be submitted to Edward Hospital pathology, Dianon Systems, and/or the University of Chicago Hospital. Therefore, it is the patient's responsibility to contact their insurance company to verify that Edward pathologists, Dianon systems and the University of Chicago Hospital are contracted with your particular PPO or HMO plans. Please inform our office/staff if your insurance company is not contracted with the above or the patient has any objections with Suburban GI using these facilities.

2. Suburban GI will call and verify insurance eligibility and request a "general description" of insurance benefits. It is **ultimately the responsibility of the patient** to know their particular plan, as the insurance company will not guarantee payment of the benefits they quote.

3. For those patients enrolled in the HMO or managed care products, Suburban GI will contact the primary care physicians referral coordinator to "initiate" referrals for surgical procedures. It is the patient's responsibility to follow through with the primary care office and have the referral "in hand" the day of the procedure.

4. Payment for insurance copays and deductibles will be collected on the day services are rendered. If no insurance is applicable, financial arrangements must be finalized before any services are rendered.

5. Please notify our insurance department immediately of any changes in your insurance plan or carrier.

A copy of this serves as the original document.

______________________________ ____________________

Patient Signature Date

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CONSENT FOR RELEASE OF INFORMATION FOR THE TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I, ____________________, hereby authorize Suburban Gastroenterology, Ltd. to use and or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, Suburban Gastroenterology, Ltd. can refuse to treat me.

I have received a copy of the Notice of Privacy Standards which more fully describes the uses and disclosures that can be made of my individually identifiable health information for the treatment, payment and health care options.

I understand that Suburban Gastroenterology, Ltd. has reserved the right to change my privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request that Suburban Gastroenterology, Ltd. restricts how my individually identifiable health information is used and or disclosed to carry out treatment, payment or health operations. I understand that Suburban Gastroenterology, Ltd. does not have to agree to such restrictions, but that once such restrictions are agreed to Suburban Gastroenterology, Ltd. must adhere to such restrictions.

______________________________________ __________
Signature of patient or patient's representative Date

______________________________________ __________
Printed name of patient or patient's representative Date

____
Relationship to patient

Authorization for Release of Information

<u>This form must be completed for ALL authorizations</u>

I hereby authorize the use or disclosure of my protected health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Patient Name: ________________________________Date of Birth:______________

Organization releasing the information:	**Organization receiving the information:**
___________________________________	___________________________________
___________________________________	___________________________________
___________________________________	___________________________________
Phone: ____________________________	Phone: ____________________________
Fax: ______________________________	Fax: ______________________________

Specific description of the information (including date of healthcare) to be disclosed:
____
____
____
____

The patient or the patient's representative must read and initial the following statements:

1. I understand that this authorization will expire on ____/____/_____
   Initials: ________

2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing. Should I do so, this action will not have any affect on any actions taken by the providing organization before they received the revocation. Initials: _______

____ _______________________
Signature of patient or patient's representative Date

Printed name of patient's representative ___________________________________
Relationship to patient ____

*****YOU MAY REFUSE TO SIGN THIS AUTHORIZATION*****

This form may not be used to release information for treatment or payment except when the information to be released is psychotherapy notes or certain research information.

PLEASE COMPLETE THIS FORM IN PEN

Suburban Gastroenterology, Ltd.
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PATIENT QUESTIONAIRE / HISTORY

NAME____ **DATE**________________
First Initial Last

SEX_______ **DOB** ____________**AGE** ___________

Height ______ **Weight** ______

MEDICAL HISTORY: (Circle all that apply)

Anemia	Blood Transfusion	Abnormal Bleeding
Anxiety	Enlarged Prostate	Breast Cancer
Arthritis	Glaucoma	Cancer of the Uterus
Asthma	Heart Murmur	Colon Cancer
Depression	Heart Rhythm Problems	Crohn's Disease
Diverticulosis	High Blood Pressure	Hypothyroid (low)
Diabetes	Heart Valve Damage	Hyperthyroid (high)
Emphysema	High Cholesterol	Other Cancer
Gallstones	Irritable (Spastic) Bowel	Prostate Cancer
Heart Attack	Kidney Stones	Seizures
Hepatitis	Pancreatitis	Stroke
Mental Illness	Ulcerative Colitis	Stomach Ulcer
Migraines	Sleep Apnea	

Other____

PREVIOUS OPERATIONS: (Circle all procedures you have had and indicate the age you were when they were done)

Angioplasty	___________	Aorta Aneurysm Surgery	___________
Appendix	___________	Carotid Artery Surgery	___________
C-Section	___________	Colon Surgery	___________
Gallbladder	___________	Coronary Artery Bypass	___________
Heart Valve	___________	Cystoscopy (Bladder)	___________
Hernia	___________	Hemorrhoidectomy	___________
Hip Surgery	___________	Knee Arthroscopy	___________
Hysterectomy	___________	Stomach for Ulcer	___________
Mastectomy	___________	Varicose Veins	___________
Pacemaker	___________	Vascular Surgery Legs	___________
Prostate Surgery	___________	Other	___________
Implantable Defibrillator	___________		

MEDICATIONS: PLEASE INCLUDE DOSAGES (List all prescriptions, over the counter drugs, aspirin, Motrin, vitamins and herbal supplements.)

____

____

____

Office use: Reviewed By ________________________________ BMI _________ Date ___________________

Patient Name ________________________________ Date ____________________

ALLERGIES TO MEDICATIONS: ____

ALLERGIES TO FOODS: ____

LATEX ALLERGY ? ____________________ **EGG ALLERGY** ? _____________________

SOCIAL HISTORY: (Circle)

Do you smoke?	Yes	No	Amount?	____________
Do you drink alcohol?	Yes	No	Frequency?	____________
Do you take Aspirin daily?	Yes	No		
Do you take illegal drugs?	Yes	No		

Occupation ____

Hobbies/Interests ____

FAMILY HISTORY: (Circle)

Bleeding Disorder	Colon Polyps	Diabetes	Stroke
Colon Cancer	Crohn's Disease	Heart Disease	Ulcerative Colitis

REVIEW OF SYSTEMS: (Circle any problems that apply to you)

Constitutional/General
- 5 lbs or more weight loss in the past yr.
- Fever within the past month
- Chills or sweats
- Chronic fatigue
- Loss of appetite

Eyes
- Blurred or double vision
- Cataracts or glaucoma

Ears, Nose, Mouth and Throat
- Hearing loss
- Ringing in the ears
- Sore throat/hoarseness
- Sinus problems
- Nose bleeds

Cardiovascular
- Chest pain or pressure
- Rapid or irregular heart beat
- Abnormal swelling in legs or feet

Respiratory
- Persistent cough
- Coughing up sputum or blood
- Exposure to Tuberculosis (TB)
- Difficulty breathing
- Bronchitis

Musculoskeletal
- Pain/stiffness/swelling in joints
- Backaches
- Muscle weakness
- Osteoporosis

Office use: Reviewed By ________________________________ Date ___________________

Patient Name ________________________________ Date ____________________

Gastrointestinal

- Nausea or vomiting
- Vomiting of blood
- Heartburn
- Gas or bloating
- Difficulty swallowing solids
- Abdominal pain
  - Location ____________________
  - Related to___________________
  - Relieved by__________________
  - Frequency___________________
- Constipation
- Diarrhea
- Blood in stool
- Dark tarry stools
- Jaundice
- Occult blood (hidden blood in stool)

Genitourinary

- Frequency of urination
- Leaking urine
- Difficulty starting urinary stream
- Burning/pain with urination
- Blood in urine
- Urinary tract infections
- Frequent night urination

Skin

- Skin rashes
- Allergic reactions

Neurological

- Frequent headaches/migraines
- Dizziness
- Problems with equilibrium
- Numbness or tingling
- Slurred speech
- Loss of consciousness

Psychiatric

- Anxiety
- Memory loss
- Depression

Hematologic/Lymphatic

- Enlarged glands (lymph nodes)
- Excessive bruising

Has any family member seen our physicians? Yes _____ No _____
Name of family member ______________________

Office use: Reviewed By ______________________________ Date __________________