

# SUBURBAN GASTROENTEROLOGY

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1243 Rickert Dr.  
Naperville, IL 60540

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

Dear Patient,

Please fill out the enclosed information packet and return this to our office within 1 week of your procedure. We are sending with your packet our new Patient link Card. This card enables us to easily capture your medical history, family history, social history and risk factors. This will allow us to have them recorded in your electronic medical record prior to your office visit with your physician. The form must be filled out with a #2 pencil.

When returning your packet please include a copy, both front and back, of your insurance cards (both primary and secondary carriers).

**Please make sure this packet is completed and returned to our office within 1 week of your procedure.**

Sincerely,

Suburban Gastroenterology, Ltd.

**Suburban Gastroenterology, LTD  
Midwest Endoscopy Center, LLC  
1243 Rickert Drive  
Naperville, IL 60540**

*Billing Hand Out*

This handout is to help patients understand how procedure(s) will be billed.

**Billings:**

After the procedure is performed you will receive 3-4 billings depending on your insurance:

- **Midwest Endoscopy Center**- which is for the facility services incurred.
- **Suburban Gastroenterology**- which is for the professional physician charges and/or pathology depending on where your specimen(s) were sent *if not billed by Dianon Systems or Edwards Hospital Laboratory*.
- **Mobile Anesthesia** which is billed directly by them and can be contacted at 773/355-5300 for any billing concerns.
- **Dianon Systems or Edward Hospital**- which is for the pathology charges depending on where your specimen(s) were sent *if not billed by Suburban Gastroenterology*.

We receive a quote of benefits and/or pre-certification/predetermination prior to your procedure(s). We encourage every patient to also call their insurance to receive a quote of benefits/notification prior to their procedure(s), so that they can be made aware of their financial responsibility. In most cases we call patients prior to their appointment as a courtesy to inform them of their financial responsibility up front. If there is no call received, the patient is more than welcome to call the office themselves and we can discuss the insurance benefits quoted.

It is fully understood that the verbal financial responsibility is only an **ESTIMATE** based on a baseline procedure, which may change after insurance benefits have been settled and/or if additional procedures are performed, such as an abnormal finding and/or polyps removed. After insurance has been settled, if there is a credit balance on either SGI or MWE account the company with credit may transfer said funds to the other company. Any remaining credit balance will be refunded back to you.

**How procedure is coded:**

Our office has been asked to schedule you for a screening colonoscopy. Patients who have screening examinations have no signs or symptoms and have a set benefit from their insurance company. **You need to be informed that if the physician performing your procedure finds a polyp or abnormality, your benefits may change and your insurance company may pay differently (as a diagnostic procedure instead of a screening procedure.)**

If you have any further questions or concerns, feel free to call our billing department at 630/527-6450 or contact member services at the number listed on your insurance card.

\*\*\* PLEASE PRINT \*\*\*

# PATIENT REGISTRATION

PATIENT NAME \_\_\_\_\_ DOB \_\_\_\_\_ AGE \_\_\_\_\_ MALE FEMALE  
FIRST INITIAL LAST

PATIENT SOCIAL SECURITY# \_\_\_\_\_ PHONE (HOME) \_\_\_\_\_ MARITAL STATUS  
PHONE (WORK) \_\_\_\_\_ PHONE (CELL) \_\_\_\_\_ S M W D

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 HEREBY AUTHORIZE THE ABOVE PHYSICIAN(S) TO RELEASE ANY INFORMATION REGARDING SERVICES RENDERED 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.

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Patient Signature

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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