NORTH SUBURBAN GASTROENTEROLOGY ASSOCIATES

Patient Registration – Please PRINT information and return to our receptionists. Thank you!

DATE: _____

LAST NAME: _____ **First Name:** _____ **Middle Initial:** ____

Home Phone #: _____/_____ **Cell Phone #:** _____/_____

Home Address: _____

Street Number & Name Apt/Unit City State Zip+4

Email address: _____

***RACE/ETHNICITY:** Alaskan Indian - American Indian - Asian - Asian Pacific American – Black – Black/Nonhispanic - Caucasian – Hispanic - Native American- White/nonhispanic - Other race or ethnicity: _____

***Language you prefer to speak in:** _____

****NOTE: Federal regulations monitoring the use of Electronic Medical Health records by physicians require us to ask the questions above.***

Soc Security #: _____ **Birthdate:** _____ **Sex:** M ☐ F ☐ **Marital Status:** S ☐ M ☐ D ☐ W ☐

Employer Name: _____ **Employer Phone #:** ____/_____x_____

Employer Address: _____

Occupation: _____

Referring Physician: _____ **Phone #:** _____/_____

Referring Physician Address: _____

Emergency Contact Name: _____ **Relationship:** _____

Emergency Contact Phone #: _____ Please add this person to your "Emergency Contacts"

Please give your HEALTH INSURANCE CARDS to the receptionist so that we may copy ALL of them*

****If you are scheduling a screening-preventative care procedure, READ and ACT on our Screening Coverage Notice provided to you at the time of scheduling your procedure – direct questions to Billing at 847-696-2336.***

PRIMARY **INSURANCE NAME:** _____

Member ID/Policy #: _____ **Group #:** _____

Ins Address: _____ **Ins Phone #:** _____

Subscriber Name: _____ **Subscriber birthdate:** _____

Relationship to Patient: ( )Self ( )Spouse ( )Child ( )Other: _____

Effective date of plan: _____ **Copay:** $_____

Subscriber Group Name: _____

SECONDARY **INSURANCE NAME:** _____

Member ID/Policy #: _____ **Group #:** _____

Ins Address: _____ **Ins Phone #:** _____

Subscriber Name: _____ **Subscriber birthdate:** _____

Relationship to Patient: ( )Self ( )Spouse ( )Child ( )Other: _____

Effective date of plan: _____ **Copay:** $_____

Subscriber Group Name: _____

This authorization must be signed so that we may bill your insurance carrier/s. Thank you.

I understand that I am responsible for my account balance regardless of delays or nonpayment by my insurance company. I agree, in the event of nonpayment, to assume the costs of interest, collection and legal action (if required). I hereby authorize RELEASE OF MY MEDICAL RECORDS NECESSARY ON MY BEHALF TO MY HEALTH INSURANCE CLAIMS DEPARTMENT IN ORDER THAT THEY MAY PROCESS AND PAY FOR MY MEDICAL CLAIMS. I hereby authorize payment of medical and/or surgical benefits to be sent to North Suburban Gastroenterology Associates, S.C. (NSGA).

_____ _____

Patient Signature/Date ***NSGA Staff Initials/Date***

NORTH SUBURBAN GASTROENTEROLOGY ASSOCIATES, S.C.

Financial Policy Statement

Your clear understanding of our practice Financial Policies and your patient financial responsibilities is important to our professional relationship. Payment of your bill is considered part of your treatment. Please call our billing department at 847-696-2336 or 708-534-9150 with any questions you may have.

- ✔ All patients must fully complete our **Patient Registration Forms**
- ✔ *If you do not have insurance,* **full payment is expected at the time of each visit**
- ✔ We accept cash, check, Visa, MasterCard, American Express and Discover

CANCELLATION OF APPOINTMENTS

All of our patients are important to us. Appointment time is allocated specifically to provide you the utmost in quality care. By providing ***at least 48 hours appointment cancellation notice,*** you allow us to help another patient in need. Repeated cancellations or failed appointments may result in a charge of $25 for office visits and $50 for procedures. Your consideration benefits all.

In order to file your claim, we must have a copy of the front and back of your insurance identification cards with the complete claims filing address as well as owner identification, policy and group numbers. Without this information, you will be billed directly. We file claims for most insurance plans. Balances that remain unpaid may be sent to our collection agency.

Managed Care Plans: EPO-HMO-PPO-POS

ALL COPAYMENTS ARE DUE AT TIME OF SERVICE. If you do not know your copayment amount, you may use our phone to call your insurance carrier. In order for your claim to be paid by your carrier, you must provide us with any required referral forms or authorizations prior to your visit. IT IS YOUR RESPONSIBILITY to verify that we are ***"in-network"*** *with your managed care plan. If you are scheduled for a procedure, you must verify that the hospital or facility is "in-network"* to avoid increased deductible and out-of-pocket cost penalties.

RE: **SCREENING BENEFITS.** You must tell us when you schedule your procedure if you are scheduling a screening procedure. Hospitals and out-patient facilities bill on the SCHEDULING diagnosis. See Well-Care, Preventative, Routine and Screening Notice.

RE: **PROCEDURES.** Patients who fail to appear for their scheduled procedures will be charged $100.00.

MEDICARE – MEDICARE REPLACEMENT PLANS

****IF YOU HAVE A MEDICARE REPLACEMENT PLAN*, you must contact our office prior to your procedure to verify that we are participating providers with that plan.** We accept regular Medicare and Railroad Medicare assignment. You are responsible only for the difference between Medicare's approved amount, the amount they pay and any deductible or co-insurance applied. If you have supplemental insurance, we will bill them directly for you. Supplemental insurance may not cover your deductible, or pay only a portion of your co-insurance due. You will receive a bill after insurance has paid. Medicare may require that you sign an "Advanced Beneficiary Notice" (ABN) for some services; we will advise you when this may be required.

USUAL AND CUSTOMARY DETERMINATIONS

We are committed to providing the best treatment possible for our patients. We charge what is usual and customary for our area. You are responsible for payment in full, regardless of an insurance company's arbitrary determination of "usual and customary".

LEGAL OR ACCIDENT CLAIMS

If you are here as the result of an accident claim, we require that you provide us with your health insurance information so that we may bill them directly, or that you pay 100% of your charges at the time of service. We also need the name, address and phone number of the accident insurance company and/or your attorney. In case of a lawsuit, we will file a lien with them for the balance. 24 HOUR NOTICE IS REQUIRED FOR COPIES OF MEDICAL RECORDS AND/OR X-RAY REPORTS; there is a FEE for this service. You will be required to sign our release form.

WORKER'S COMPENSATION

Patient being seen as a result of work-related injuries are still responsible for charges incurred by them. Please notify our office if you have such a claim so that *prior to the time of your visit* we may verify coverage of your charges by your employer. If we cannot verify coverage, you will be responsible for payment of your charges. If your employer does not remit payment for your charges within a reasonable period of time, we will bill you directly for your charges.

Signature of Patient or Responsible Party	NSGA Staff Initials Date
Print Patient's Name	DOB

NSGA Medication Flowsheet for

PATIENT Name: _____ **Date of birth:** _____ **Today's Date:** _____

	Include prescription medications, over-the-counter meds, vitamins and supplements **Name of Medication** ***EXAMPLE**: Lasix*	**Dosage** *40 mg*	**Directions for Taking Medication** *1 pill ea morning*	**PHARMACY NAME:** _____ **PHARMACY PHONE:** _____ **PHARMACY ADDRESS:** _____ _____ _____ **Verification Dates by NSGA Staff**						
1.										
2.										
3.										
4.										
5.										
6.										
7.										
8.										
9.										
10.										
11.										
12.										
13.										
14.										

Please list all medication you may be <u>ALLERGIC</u> to and the reaction it causes:

1. _____
2. _____
3. _____

North Suburban Gastroenterology Associates, SC

711 Devon Avenue, Park Ridge IL 60068

Anthony A Grande, MD, FACN
David K Yoon, MD
Michelle M Lipman, MD
Jeffrey T. Brasky, DO

847-696-3176
FAX: 847-696-2678

Review of Systems, Personal History and Family History

Patient Name: _____ Date of birth: _____

Today's Date: _____ Occupation: _____

Reason for visit:

a. **Schedule a SCREENING COLONOSCOPY** ☐ **YES** ☐ **NO**
b. _____
c. _____
d. _____

Other Medical Conditions:

a. _____
b. _____
c. _____
d. _____

Surgery/Year: _____

_____

Please list ALL MEDICATIONS you are taking, as well as all medications you may be ALLERGIC to on our "Medication Flowsheet"

Personal History of:

☐ Cancer ☐ Polyps ☐ Ulcer ☐ Liver Disease ☐ Pancreatitis

Family History of:

☐ Cancer ☐ Polyps ☐ Ulcer ☐ Liver Disease ☐ Pancreatitis

Note any illnesses; if deceased, give age and cause of death:

Father: _____

Mother: _____

Brothers/Sisters: _____

Children: _____

Spouse: _____

Do you smoke? ___ NO ___ YES

Number of packs per day _____

Number of years smoked _____

Do you use alcohol? ___ NO ___ YES

Number of drinks per week _____

Number of years drinking _____

Reviewed by _____ Date _____

Page 1 of 2 – turn over and complete page 2

Review of Systems, Personal History and Family History – page 2 of 2

for Patient:

Constitutional

Recent weight change	___ No	___ Yes
Fever	___ No	___ Yes
Fatigue	___ No	___ Yes
Malaise	___ No	___ Yes

Eyes

Blurred vision	___ No	___ Yes
History of Glaucoma	___ No	___ Yes

Ears-Nose-Mouth-Throat

Earache	___ No	___ Yes
Hearing loss	___ No	___ Yes
Ringing in ears	___ No	___ Yes
Mouth sores	___ No	___ Yes
Nasal discharge	___ No	___ Yes
Throat pain	___ No	___ Yes

Cardiovascular

Chest pain or discomfort	___ No	___ Yes
Fast heart rate or palpitations	___ No	___ Yes
Swelling of ankles	___ No	___ Yes

Respiratory

Chronic cough	___ No	___ Yes
Spitting up blood	___ No	___ Yes
Shortness of breath	___ No	___ Yes
Wheezing	___ No	___ Yes
Snoring	___ No	___ Yes
Sleep Apnea	___ No	___ Yes

Genitourinary

Burning during urination	___ No	___ Yes
Blood in urine	___ No	___ Yes
Increased urinary frequency	___ No	___ Yes

Musculoskeletal

Joint pain, localized	___ No	___ Yes
Joint swelling, localized	___ No	___ Yes
Back pain	___ No	___ Yes
Muscle pain	___ No	___ Yes

Skin

Itching	___ No	___ Yes
Rashes	___ No	___ Yes

Comments:

Gastrointestinal

Poor/decreased appetite	___ No	___ Yes
Difficulty in swallowing	___ No	___ Yes
Heartburn	___ No	___ Yes
Nausea	___ No	___ Yes
Vomiting	___ No	___ Yes
Bloating	___ No	___ Yes
Belching	___ No	___ Yes
Regurgitation	___ No	___ Yes
Constipation	___ No	___ Yes
Diarrhea	___ No	___ Yes
Abdominal pain	___ No	___ Yes
Change in bowel habits	___ No	___ Yes
Red blood in bowel movement	___ No	___ Yes
Black or bloody stools	___ No	___ Yes
Bowel movement frequency	___ No	___ Yes
Bowel urgency	___ No	___ Yes
Anemia-*if Y bring labs*	___ No	___ Yes

Neurological

Headaches	___ No	___ Yes
Convulsions/seizures	___ No	___ Yes
Numbness	___ No	___ Yes
Motor disturbances	___ No	___ Yes
Strokes	___ No	___ Yes

Psychological

Memory loss or confusion	___ No	___ Yes
Confused/disoriented	___ No	___ Yes
Depression	___ No	___ Yes
Anxiety	___ No	___ Yes

Endocrine

Heat intolerance, consistent	___ No	___ Yes
Cold intolerance, consistent	___ No	___ Yes

Hematological

Easy bleeding	___ No	___ Yes
Bruising tendency	___ No	___ Yes
Past transfusion	___ No	___ Yes

Are you pregnant? ___ No ___ Yes

Reviewed by _____ Date _____

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Phone:847-696-3176
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Dr. Anthony Grande, MD, FACN
Dr. David K Yoon, MD
Dr. Michelle Lipman, MD
Dr. Jeffrey T Brasky, DO

Written Disclosures

Please let us know if we may LEAVE A PHONE MESSAGE for you by checking one of the following:

_____ The doctors and staff of North Suburban Gastroenterology Associates, S.C. (NSGA), **have my permission** to leave messages regarding my medical condition and/or finances on my answering machine/voice mail/cell phone.

_____ The doctors and staff of NSGA **do not have my permission** to leave messages regarding my medical condition and/or finances on my answering machine/voice mail.

_____ I do not have an answering machine/voice mail.

Please let us know WHOM WE MAY SPEAK TO if you are not available to take our call:

Until further written and/or verbal notice, I _____ **(PRINT patient name)** authorize the people listed below to discuss my medical conditions and finances with NSGA:

Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship

Do you have a Power of Attorney for medical and financial decision-making? YES – NO

If YES: Name:_____ Contact Number: _____

Relationship to patient: _____
Please provide a copy of the Power of Attorney notice for our files

Do you have a Living Will on file? YES – NO
IF YES, who has the authorization to use this document? Name: _____

Contact Number: _____ Relationship to patient: _____

_____ _____

Patient Signature **Date** NSGA Staff Initials/Date
NOT VALID IF NOT SIGNED AND DATED

North Suburban Gastroenterology Associates SC

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711 Devon Avenue, Park Ridge IL 60068
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CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I, _____, authorize North Suburban Gastroenterology Associates SC (NSGA) 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, NSGA can refuse to treat me.

I have been informed that NSGA has prepared a Notice of Medical Privacy Practices which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and health care operations. I understand that I have the right to review such Notice prior to signing this consent.

I understand that I may revoke this consent at any time by notifying NSGA in writing, but if I revoke my consent, such revocation will not affect any actions that NSGA took before receiving my revocation.

I understand that NSGA has reserved the right to change his/her privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request that NSGA restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or healthcare operations. I understand that NSGA does have to agree to such restrictions, but that once such restrictions are agreed to, NSGA must adhere to such restrictions.

_____ _____

Patient or Patient Representative Signature **Date**

_____

PRINTED Patient Name

_____ _____

Relationship to the Patient **NSGA Staff Initials/Date**

080210

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North Suburban Gastroenterology Associates, S.C

Receipt of Notice of Privacy Practices Form

I, _____, hereby acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available upon my request.

_____ _____

Patient Signature Date Staff Initials

_____ _____

Patient Name -Please Print DOB