Print Form

SYRACUSE GASTROENTEROLOGICAL ASSOCIATES, P.C.

CNY Medical Center • 739 Irving Ave, Ste 400 • Syracuse, NY 13210 • (315) 234-6677 • Fax (315) 234-4808
Clay Medical Center • 8100 Oswego Road, Suite 140 • Liverpool, NY 13090 • (315) 641-1966 • Fax (315) 234-6696
Family Health Center • 3045 John Trush Jr Blvd • Cazenovia, NY 13035 • (315) 234-6677 • Fax (315) 234-6696
Community Memorial Hospital • 150 Broad Street • Hamilton, NY 13346 (procedures only)

MARK H. KASOWITZ, MD • MICHAEL S. SIPPLE, MD • DENNIS W. REEDY, MD • DAVID S. KAPLAN, MD
INTIKHAB IQBAL, MD • ADAM M. BERG, MD • KIRAN ANNA, MD • VINCENT LOCOCO, RPA-C • NICOLE D. SINKLER, NP-C

Visit us at Syracusegastro.com

RECALL

Please do not write "no changes" on your forms. Make sure you fill out <u>all areas</u> on your paperwork, or it may be returned to you to complete.

Once we receive your paperwork please be aware that you may not hear from us for 2-4 weeks as your paperwork has to be reviewed by your physician before we can schedule you.

If you have any questions please feel free to contact our office at 315-234-6677.

Thank you!
Syracuse Gastroenterological Associates, PC

Family Health Center
3045 John Trush Jr Blvd
(Off of Route 20)

We are expanding!

We will be seeing patients for office visits in

Cazenovia, NY
February 2015

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Community Memorial Hospital, 150 Broad St, Hamilton, NY 13346 (procedures only)

RECALL / UPDATE

Preferred location for my procedure:

☐ Syracuse ☐ Hamilton

Date: _____

You are due for a recall procedure and we must update your medical records in order to schedule. Please complete and return all paperwork to our office. After your doctor reviews it, you will be sent an appointment in the mail. ***If any of the information on this form changes prior to your procedure date you MUST contact our office.***

Name: _____ Date of Birth: _____

Height _____ Weight _____

Primary Care Physician: _____ Cardiologist: _____

Other specialists you see _____

Pharmacy (Name/address/telephone and fax): _____

Social History:

Occupation _____ Caffeine intake _____

Do you drink alcohol? ☐ No ☐ Yes _____ Number of children _____

Smoking status: ☐ Never ☐ Quit _____ ☐ Currently (started) _____ (Qty) _____

Do you use recreational drugs? ☐ No ☐ Yes (what/how much)_____

Exercise (type) _____ (frequency) _____

Please list all *current and past* medical conditions or problems, including kidney or heart failure, along with dates.

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Please list *any operations* you have had, including heart surgeries or procedures, along with the dates.

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Please list any colonoscopy, flexible sigmoidoscopy, barium enema or upper endoscopies performed ***since last seen in our office.*** (Include dates and where you had it done)

1. _____ 2. _____

PLEASE TURN OVER

Patient Name _____ DOB_____

RECALL / UPDATE
PG 2

Is there any one ***in your family*** who has had colon cancer or colon polyps?
*** Please state how they are related to you and which they had.

1. _____ ☐ Colon polyps ☐ Colon cancer
2. _____ ☐ Colon polyps ☐ Colon cancer
3. _____ ☐ Colon polyps ☐ Colon cancer
4. _____ ☐ Colon polyps ☐ Colon cancer
5. _____ ☐ Colon polyps ☐ Colon cancer
6. _____ ☐ Colon polyps ☐ Colon cancer

Please list **all your current medications**, including over-the-counter medications. **If you are taking blood thinners (examples: Pradaxa, Plavix, Aspirin or Coumadin) please indicate the reason.**

	Medication	Dose	Frequency	Reason
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				

Please list all drug **allergies**. List the medication and the reaction.

1. _____ 3. _____
2. _____ 4. _____

Please check Yes or No:

☐ No ☐ Yes **Diabetic**
☐ No ☐ Yes **Dialysis**
☐ No ☐ Yes **Defibrillator/Pacemaker**
☐ No ☐ Yes **Blood thinner**
☐ No ☐ Yes **MRSA, VRE, OR ESBL POSITIVE (CIRCLE WHICH ONE)**
☐ No ☐ Yes **Using Oxygen 24/7? How many Liters? _____**
☐ No ☐ Yes **Sleep apnea (what doctor diagnosed _____)**
☐ No ☐ Yes **C-Diff** (if yes, date_____)
☐ No ☐ Yes **Translator needed?** (language_____)
☐ No ☐ Yes **Clotting disorder** (if yes, type_____)

Please write any notes/requests here:

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Today's Date: _____ Sex: ☐ M ☐ F

Name (last) _____ (First) _____ (Middle) _____ Date of Birth _____

Address _____ SSN _____

City _____ State _____ Zip code _____ County _____

Home Telephone # _____ Cell Phone _____ Work Phone _____

For access to our patient portal, **PLEASE PRINT your email address:** _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Civil Union ☐ Unknown ☐ Other

Race (circle one) ☐ White ☐ American indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian ☐ More than one race ☐ Unreported/Declined

Ethnicity (circle one) ☐ Hispanic or Latino ☐ Not hispanic or Latino ☐ Unreported/Declined **Language** _____

Other doctors:

Primary Care MD: _____ Address: _____ Phone: _____

Referred by: _____ Address: _____ Phone: _____

Emergency Contact:

Name: _____ Relationship _____ Sex: ☐ M ☐ F

Home Telephone #:: _____ Cell Phone _____ Work Telephone #: _____

Insurance Information:

1. Primary Insurance Name: _____ ID#: _____

Subscriber's Name: _____ Subscriber's DOB: _____

Subscribers Employer _____ Relationship to subscriber _____ Group #: _____

Claims address _____ Phone _____

2. Secondary Insurance Name: _____ ID#: _____

Subscriber's Name: _____ Subscriber's DOB: _____

Subscribers Employer _____ Relationship to subscriber _____ Group #: _____

Claims address _____ Phone _____

3. Other insurance (if applicable): _____ ID#: _____

Subscriber's Name: _____ Subscriber's DOB: _____

Subscribers Employer _____ Relationship to subscriber _____ Group #: _____

Claims address _____ Phone _____

PLEASE TURN OVER ⇨

ASSIGNMENT OF INSURANCE BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION

1. STATEMENT TO AUTHORIZE PAYMENT OF INSURANCE BENEFITS. I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, Private insurance, and any other health plan to Syracuse Gastroenterological Associates, P.C. This assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid or allowed by insurance. I hereby authorize said assignee to release all information necessary to secure payment. In the event my account is assigned for collection, I agree to pay all costs of collection including reasonable attorney fees.

PATIENTS SIGNATURE _____ DATE : _____

2. I acknowledge that I am aware that I can be held personally responsible for payment of some or all medical expenses incurred for services at or ordered by Syracuse Gastroenterological Associates, PC.
I have been given the option of rescheduling my appointment for a later date if I elect not to be seen today.

I UNDERSTAND AND AGREE TO PAY FOR ALL SERVICES PROVIDED THAT MAY NOT BE A PAID BENEFIT UNDER MY HEALTH INSURANCE POLICY FOR ONE OF THE REASONS OUTLINED BELOW.

1. An insurance referral was not received from the Primary Care Provider
2. I do not have health insurance
3. The service may not be deemed medically necessary
4. The service is not a covered benefit under the terms of my insurance contract
5. Service(s) applied toward deductible
6. Prior authorization was not obtained for my procedure (and/or any related charges).
7. Prior authorization was not obtained for any outside testing, radiology, labs, or referrals to another doctor.
8. Co-payments and non-covered services are expected at the time of service.

This waiver will stay in effect until such time I terminate treatment with Syracuse Gastroenterological Associates, P.C. by written letter.

PATIENTS SIGNATURE _____ DATE : _____

3. I AM AWARE THAT THE OFFICE HAS NO SHOW/LATE CANCELLATION POLICIES:

1. Office visit appointments require 1 business day prior notice or you may be charged a fee of $30.00.
2. Appointments scheduled at our Endoscopy suite (Syracuse Endoscopy Associates) require 3 business days prior notice or you may be charged a fee of $150.00.
3. Capsule Endoscopies require 3 business days prior notice or you may be charged a fee of $150.00.

PATIENTS SIGNATURE _____ DATE : _____

MEDICARE PATIENTS PLEASE SIGN: STATEMENT OF AUTHORIZATION FOR PAYMENT OF MEDICARE BENEFITS. I certify that the information by me in applying for payment under the Title XVIII of the Social Security Act is correct. I authorize any holder of medical information about me to release to the Social Security Administration, or its carrier, any information about me to process my Medicare claim. I request that payment under the Medical Insurance Program be made to Syracuse Gastroenterological Associates, P.C. for services rendered to me during the period of my treatment or lifetime.

MEDICARE BENEFICIARY SIGNATURE _____ DATE : _____

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Notice of Privacy Practices and Authorization for Release of Information

Patient Name: _____ Birth Date: _____

- *I authorize Syracuse Gastroenterological Associates, PC to release protected health information, if necessary, about the above-named patient to the people named below.*
- *I understand that Syracuse Gastroenterological Associates, PC may need to discuss my medical condition and may need to share my medical records with any physician, physician extender, nurse, therapist, family member, friend, or other health care provider who is involved in my care.*

Home _____ Cell _____ Work _____

☐Yes ☐No **AT MY HOME AND/OR CELL:** SGA may leave messages (for appointment reminders, lab/x-ray/other test results) on my telephone answering machine at my home and/or cell.

☐Yes ☐No **AT MY WORK:** SGA may leave messages (for appointment reminders, lab/x-ray/other test results) on my telephone voice mail or with the operator/secretary at my work.

LIST BELOW ANY PERSON(S) THAT WE MAY SPEAK WITH: Please list any (parents, family member, friend, caretaker, or other) that SGA may speak with about your medical condition (including appointment reminders, lab/x-ray/other test results, or messages from the doctor) and/or billing information.

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

- *I am aware that I can obtain a copy of the SGA Patient Privacy Notice in the office or by mail if requested.*
- *I understand that SGA has an automated system that calls to remind me of my appointment and that appointment reminders, lab, x-ray, or other test results may come in the mail to my home.*
- *I understand that I have the right to change this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending written notification. I understand that any change in this authorization is effective from the date signed going forward.*
- *I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.*
- *I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned upon signing. This authorization shall be in effect until revoked by the patient.*

_____ _____

Signature of Patient Date

_____ _____

Signature of Representative Relationship