

Date: _____

COLON RECTAL ASSOCIATES OF CENTRAL NEW YORK, LLP

North Medical Center
5100 West Taft Rd., Suite 4A
Liverpool, NY 13088
(315) 458-2211 • Fax (315) 452-9025

Township 5
260 Township Blvd., Suite 30
Camillus, NY 13031
(315) 991-8338 • Fax (315) 991-8345

THIS IS A CONFIDENTIAL RECORD. INFORMATION CONTAINED HERE WILL NOT BE RELEASED EXCEPT WHEN YOU AUTHORIZE US TO DO SO IN WRITING. PLEASE COMPLETE ACCURATELY.

PATIENT INFORMATION

Name _____
Address _____
Phone#1: _____ Home Work Cell
Phone#2: _____ Home Work Cell
Date of Birth _____ Age _____ Sex: M F
Social Sec. # _____
E-mail address _____
Married Single Divorced Widowed
Race: _____ Ethnicity: _____
Non-Hispanic, Hispanic, Other
Language Preference: English or Other: _____

Emergency Contact: _____
Relationship _____ Phone # _____

Referring Physician:
Name _____
Address _____
Phone # _____

Primary Care Physician:
Name _____
Address _____
Phone # _____

Pharmacy:
Name _____
Phone # _____

In your own words, please describe why you are coming to this office:

PRIMARY INSURANCE

BRING YOUR INSURANCE CARDS TO THE APPOINTMENT

Name of Insurance _____
Holder _____
Social Sec. # _____
Birthdate _____ Sex: M F
Employer _____
Relationship to Patient _____
Insurance ID # _____

SECONDARY INSURANCE

Name of Insurance _____
Holder _____
Social Sec. # _____
Birthdate _____
Employer _____
Relationship to Patient _____
Insurance ID # _____

PATIENT EMPLOYMENT

Employed Retired Other
Employer Name: _____
Occupation: _____

ALLERGIES

Height _____ Weight _____

Do you have any allergies to medications, testing dye or latex (as in gloves)? No Yes (Please list below)

Name of Medication _____ Circle reaction: Hives Difficulty Breathing or Swallowing Itching Swelling Rash
_____ Circle reaction: Hives Difficulty Breathing or Swallowing Itching Swelling Rash
_____ Circle reaction: Hives Difficulty Breathing or Swallowing Itching Swelling Rash

Name: _____

FAMILY MEDICAL HISTORY

	# Alive	# Deceased	Medical Problems / Cause of Death
Mother	_____	_____	_____
Father	_____	_____	_____
Please list how many sisters, brothers, or children and their medical problems if any			
Sisters	_____	_____	_____
Brothers	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Check if any **family members** have:

- | | | |
|---|---|--|
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Colon Polyps or Tumors | <input type="checkbox"/> Ovarian Cancer | <input type="checkbox"/> Heart Trouble |
| <input type="checkbox"/> Ulcerative Colitis | <input type="checkbox"/> Uterine Cancer | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Other type G.I. Cancer | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Irritable Bowel | <input type="checkbox"/> Other type of Cancer | |

YOUR MEDICAL HISTORY

LIST ALL MEDICAL CONDITIONS YOU ARE BEING TREATED FOR/HAVE BEEN TREATED FOR:

Do you have:

- | | |
|---|--|
| <input type="checkbox"/> Mitral or Aortic Valve Replacement | <input type="checkbox"/> Heart Pacemaker (please provide card) |
| <input type="checkbox"/> Hip, knee or shoulder replacement | <input type="checkbox"/> Implanted Defibrillator (please provide card) |
| <input type="checkbox"/> Cardiac Stents | |

LIST ALL SURGERIES OR OPERATIONS YOU HAVE EVER HAD AND THE YEAR:

Date: _____ Colonoscopy _____ CT Scan Abd. Pelvis _____ Upper GI Series
 _____ Flexible Sigmoidoscopy _____ Barium Enema _____ Chest X-Ray

Have you ever had:

- | | | |
|--|---|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Irritable Bowel | <input type="checkbox"/> Other type of cancer |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Diverticulitis | Where: _____ |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diverticulosis | _____ |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Blood in Stool | _____ |
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Abdominal Pain | _____ |
| <input type="checkbox"/> Colon Polyps or Tumors | <input type="checkbox"/> Constipation | |
| <input type="checkbox"/> Ulcerative Colitis | <input type="checkbox"/> Diarrhea | |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Rectal Bleeding | |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Blood Clot, Legs | |

Name: _____

MEDICATIONS YOU ARE CURRENTLY TAKING INCLUDING ASPIRIN AND OTHER OVER THE COUNTER DRUGS:

Medication	Dose	What are you taking it for?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Review of Symptoms

Have you ever had:

Yes No
(if yes, circle symptoms in list)

- RESPIRATORY:** Any shortness of breath, asthma, emphysema, COPD, or cough? _____
- Do you smoke?** _____ **When did you quit?** _____
- Sleep Apnea?** _____ **If yes, need CPAP Machine?** _____
- CARDIOVASCULAR:** Any chest pain, palpitations, high blood pressure, irregular beats, heart murmur, or valve problems? _____
- Cardiologist Name _____ Phone _____
- URINARY (GU):** Any hesitancy, loss of control of bladder or bowel, dysuria, menstrual problems, blood in urine, kidney stones, or loss of sexual activity? _____
- BLOOD/LYMPH:** Any bleeding tendencies, lymph node enlargement or pain, anemia, excessive bleeding disorder? _____
- NEUROLOGICAL:** Any problems with speech, swallowing, numbness, stroke, change in sensation, TIA, headaches? _____
- CONSTITUTIONAL:** Any weight loss, or general fatigue? _____
- EYES:** Any blurring, trauma, glasses? _____
- ENT & MOUTH:** Any deafness, sinus infection, ear ringing, hoarseness, or dizziness? _____
- GLANDULAR:** Any problems with blood sugar, diabetes, growth or hair changes, hyperactivity, or hypoactivity? _____
- MUSCULOSKELETAL:** Any sprains, pain, swelling, arthritis, stiffness, or muscle wasting? _____
- SKIN/BREAST:** Any color changes, rashes, lesions, scars, masses, or ulcers? _____
- PSYCHOLOGICAL:** Any depression, mood changes, hallucinations, or sleep disturbances? _____
- IMMUNOLOGIC:** Any dermatitis, eczema, itching, or other allergic problems? _____
- SOCIAL:** Any alcohol use? _____
If yes, frequency _____
- PREGNANCY:** Number of children? _____
Number of vaginal deliveries? _____
Number of C-Sections? _____

OTHER: _____

Name: _____

Colon Rectal Associates of Central New York, LLP

FINANCIAL, CONSENT AND CONTACT POLICIES

We believe that a part of good healthcare is to communicate our policies to our patients. We are dedicated to providing the best possible care for you, and we want you to completely understand our financial, cancellation, consent and contact policies.

- 1. PAYMENT** is expected at time of service. We accept cash, check, or credit card. Patient responsibility will include any unmet deductible, co-insurance, co-payment, or charges not covered charges by your insurance company. If you do not carry insurance, payment in full is expected at the time of your visit. We request a copy of your insurance card(s) and a valid picture ID to ensure identity.
- 2. Cancellation/No-show Fee:** I understand that if it becomes necessary to cancel an office appointment, I need to call the office at least 24 hours in advance or a \$50 cancellation fee may apply. If I need to cancel a procedure (colonoscopy or surgery) for personal scheduling reasons, I must contact the office at least 72 hours prior to my procedure or a \$100 cancellation fee may apply. These fees are not reimbursable by your insurance company.
- 3. INSURANCE-** We participate with most insurances. A list of these insurances is available upon request. We will file all insurance claims. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. If your insurance company does not pay the practice within a reasonable period of time, you will be billed. If we later receive payment from your insurer, we will refund any overpayment to you.

* If our doctors are not listed in your plan's network, you may be responsible for payment. If you are insured by a plan with which we are out of network, we will prepare and send the claim in for you. The insurer may send payment directly to you and therefore, our charges are due at the time of service. Due to the many different insurance products on the market, our staff cannot guarantee your eligibility and coverage. Be sure to check with your insurer's member benefits department about services and physicians before your appointment. Many web sites have erroneous information and are not a guarantee of coverage. You are responsible for obtaining a properly dated referral if required by your insurer and responsible for payment if your claim rejects for the lack of one.

Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered"; you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office

- 4. RETURNED CHECKS** will incur a \$30.00 service charge. You will be asked to bring cash, money order, certified funds or a credit card to cover the amount of the returned check plus the \$30 service charge to pay the balance prior to receiving services from our staff or the physician. Stop payments constitute a breach of payment and are subject to the \$30 service fee and collections action.
- 5. BILLING PROCEDURE:** The billing department will generate a **patient bill** after insurance has paid, or if there is no valid insurance. This bill is sent directly to the patient and is the patient's responsibility in full. If no payment is made or contact by the patient for consideration of a payment plan, a second bill will be generated with a notice of an overdue balance. The third bill will notify the patient that it is their Final Notice and Collection is pending if payment is not made immediately. The time frame from patient's first billing to collection is approximately 9 weeks.

Name: _____

6. **BILLING OFFICE:** If you have any questions in regard to any of your billing statements, our account receivable staff is available to assist you. **Call 315-452-9022.**
7. **COLLECTION FEES:** I understand that in the event my account is placed in collections a \$15 administrative fee will be added to my outstanding balance. Other expenses incurred in the process of recovering the outstanding debt may also be added to your liability including but not limited to late fees, collection agency fees, court costs, interest and fines. I understand that these additional fees will be my personal responsibility to pay in full.
8. **RESPONSIBILITY FOR PAYMENT:** I understand that I, personally, am financial responsible to **COLON RECTAL ASSOCIATES OF CENTRAL NEW YORK, LLP** for charges not covered by the assignment of insurance benefits.
9. **ASSIGNMENT OF INSURANCE BENEFITS:** I hereby assign, transfer, and set over directly to **COLON RECTAL ASSOCIATES OF CENTRAL NEW YORK, LLP** sufficient monies and/or benefits to which I may be entitled for professional and medical care, to cover the costs of the care and treatment rendered to myself or my dependent in said office. I authorize Colon Rectal Associates of CNY, LLP to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance or health plan administrator to release such information to Colon Rectal Associates of CNY, LLP.
10. **RELEASE OF INFORMATION:** I hereby authorize and direct **COLON RECTAL ASSOCIATES OF CENTRAL NEW YORK, LLP** to release to governmental agencies, insurance carriers, or others who are financially liable for such professional and medical care, all information needed to substantiate claim and payment.

I have read and understand the practice's policies and I agree to be bound by its terms.

I also understand and agree that such terms may be amended by the practice at any time in the future.

Signature of Patient (or Guarantor, if applicable)

Date

Please print the name of the patient

Colon Rectal Associates of Central New York, LLP

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Liverpool, NY 13088
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Web Site: colonrectalhealth.com

New Location as of March 2016
260 Township Blvd., Suite 30
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