Date: _____

# COLON RECTAL ASSOCIATES OF CENTRAL NEW YORK, LLP


Glacier Creek Office Park - Bldg. II
6711 Towpath Rd., Suite 175
East Syracuse, NY 13057
(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 # _____

## PRIMARY INSURANCE

**BRING YOUR INSURANCE CARDS TO THE APPOINTMENT**

Name of Insurance _____

Subscriber _____

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: _____

_____

**In your own words, please describe why you are being seen in this office:**

_____

**Height:** _____ **Weight:** _____

## ALLERGIES

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:

- ____ Colon Cancer
- ____ Colon Polyps or Tumors
- ____ Ulcerative Colitis
- ____ Crohn's Disease
- ____ Irritable Bowel
- ____ Breast Cancer
- ____ Ovarian Cancer
- ____ Uterine Cancer
- ____ Other type G.I. Cancer
- ____ Other type of Cancer
- ____ Diabetes
- ____ Heart Trouble
- ____ High Blood Pressure
- ____ Stroke

## YOUR MEDICAL HISTORY

**Sexual Orientation Please check: ___straight (heterosexual), ___gay, ___bisexual, ____ other**

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

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

Do you have:

- _____ Mitral or Aortic Valve Replacement
- _____ Hip, knee or shoulder replacement
- _____ Cardiac Stents
- _____ Heart Pacemaker (please provide card)
- _____ Implanted Defibrillator (please provide card)
- _____ Upcoming Joint Replacement

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

_____

_____

_____

**Date:**

- _____ **Colonoscopy**
- _____ **Flexible Sigmoidoscopy**
- _____ **CT Scan Abd. Pelvis**
- _____ **Upper GI Series**

Have you ever had:

- ____ Diabetes
- ____ Heart Trouble
- ____ High Blood Pressure
- ____ Stroke
- ____ **Colon Cancer**
- ____ **Colon Polyps or Tumors**
- ____ **Ulcerative Colitis**
- ____ **Crohn's Disease**
- ____ **Seizures**
- ____ Irritable Bowel
- ____ Diverticulitis
- ____ Diverticulosis
- ____ Blood in Stool
- ____ Abdominal Pain
- ____ Constipation
- ____ Diarrhea
- ____ Rectal Bleeding
- ____ Blood Clot, Legs
- ____ Other type of cancer

Where: _____

_____

_____

_____

**Name:**_____

***Review of Symptoms***

| Have you ever had: | | Yes | No |
|---|---|---|---|
| | | ***(if yes, circle symptoms in list)*** | |
| **ONCOLOGY:** | Do you have an oncologist?<br>**Oncologist Name** _____ **Phone** _____ | ____ | ____ |
| **GASTROENTEROLOGY:** | Do you have an gastroenterologist?<br>**Gastroenterologist Name** _____ **Phone** _____ | ____ | ____ |
| **RESPIRATORY:** | Any shortness of breath, asthma, emphysema, COPD, or cough?<br>**Do you smoke?** ____ **When did you quit?** _____<br>**Sleep Apnea?** ____ **If yes, need CPAP Machine?** ____<br>**Pulmonogist Name** _____ **Phone** _____ | ____ | ____ |
| **CARDIOVASCULAR:** | Any chest pain, palpitations, high blood pressure, irregular beats, heart murmur, or valve problems?<br>**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?<br>**Urologist Name** _____ **Phone** _____ | ____ | ____ |
| **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?<br>**Neurologist Name** _____ **Phone** _____ | ____ | ____ |
| **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 of 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?<br>If yes, frequency _____ | ____ | ____ |
| **PREGNANCY:** | Number of children? _____<br>Number of vaginal deliveries? _____<br>Number of C-Sections? _____ | | |
| **OTHER PHYSICIANS:** | _____ | | |

Name:_____

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

| Medication | Dose | What are you taking it for? |
| --- | --- | --- |
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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 $200 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. **RESPONSIBILTY 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**

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