MIDWEST
Endoscopy Center
healthy, for life

Physicians of Suburban Gastroenterology and Midwest Endoscopy Center: Dinesh Jain, MD. Scott Berger, MD. Sushama Gundlapalli, MD. Darren Kastin, MD. Ravi Nadimpalli, MD. Jennifer Frankel, MD.

New Patient Package

We would like to welcome you and confirm your appointment.

Day _____

Date _____

Time _____

Place Midwest Endoscopy Center, 1243 Rickert Dr., Naperville, IL 60540

We have enclosed a map and driving directions.

In Advance of your Appointment

Please plan to bring with you a list of current medications you are taking and any records or tests that pertain to the reason you are seeing the physician (such as upper GI Xrays, any recent blood work, ultrasounds or CT scans). Also bring your insurance card. If your insurance is an HMO, POS, EPO or managed care plan, please remember your authorization number or referral. All co-pays, deductibles and non-insured patients will be expected to make payment at the time of service.

We are sending with your packet a **patient link card**. This card enables us to easily capture your medical history, family history, social history and risk factors, and have them recorded in your electronic medical record prior to your appointment. The form must be filled out with a #2 pencil.

We ask that you complete the enclosed registration form and link card, and sign where indicated. Please bring these forms with you on your appointment date. If you are unable to complete these materials before your appointment date, please arrive 30 minutes early to do so. As a courtesy to other patients, if you cannot arrive on time, you may have to be rescheduled.

Because of the number of patients waiting to receive medical care, we need to insure that all available appointments are used. In the event that you are unable to keep your appointment, please call 630.527.6450 within 2 working days so that we may offer your time to another patient.

Thank you for choosing Midwest Endoscopy Center and Suburban Gastroenterology. We look forward to caring for you.

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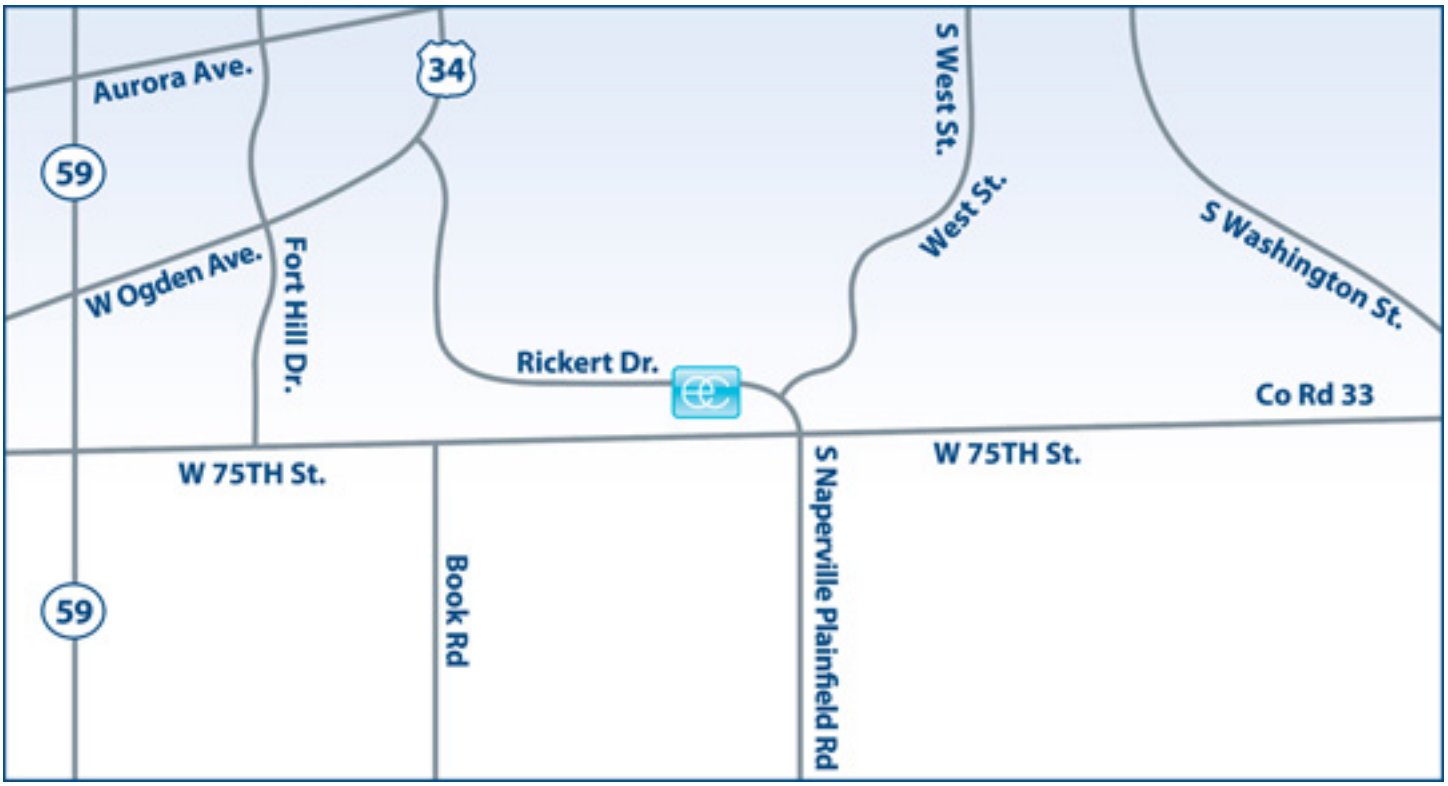
Location



1243 Rickert Drive Naperville, IL 60540 630.527.6450

Driving Directions

From the north: Take I-355 South. Exit on 75th St. Turn right onto 75th St., heading west toward Rickert Dr. (same road as Plainfield/Naperville Road). Turn right at the stoplight for Rickert Dr. Turn Left at the side street, River Rd.

From the south: Take Rt. 53 North. Turn Left (heading West) on 75th St. to Rickert Drive (same road as Plainfield/Naperville Road). Turn Right at stoplight for Rickert Drive. Turn Left at side street, River Road.

From the east: Take Ogden Ave (Rt. 34) west. Turn Left on Rickert Dr. Turn Right on side street, River Road.

From the west: Take I-88 East . Exit Rt. 59 and turn right (south). Take Rt. 59 to Ogden Ave. (Rt. 34). Turn left on Ogden Ave. (Rt. 34) to Rickert Dr. Turn right on Rickert Dr. Turn right on side street, River Rd.

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Patient Registration **please print clearly**

Patient name_____ DOB_____ Age_____ ❑ Male ❑ Female
first initial last

Social Security # _____ Marital status (circle 1) S M W D

Home phone _____ Work phone _____ Cell phone _____

Address _____
street city state zip county

Email _____ May we use your e-mail to send results and correspondence? ❑Yes ❑No

Primary care doctor _____ Referring doctor _____

Patient's employer _____

Employer's address _____ Phone _____

Emergency contact_____ Relationship _____

Emergency contact home phone _____ Work phone____ _____

Do you have advance directives (living will)? _____ _____

Primary Insurance Co. _____ID # _____ Group # _____

Insurance Co. address_____
Street city state zip

Policy holder name (if other than patient)_____ Relationship_____

Policy holder DOB _____ Policy holder Social Security# _____

Policy holder place of retirement _____

Secondary Insurance Co. _____ ID # _____ Group # _____

Insurance Co. address_____
Street city state zip

Policy holder name (if other than patient)_____ Relationship_____

Policy holder DOB _____ Policy holder Social Security# _____

Policy holder place of retirement _____

Authorization to release medical information and claim payment authorization: I authorize the above physicians to release any information regarding services rendered by the physicians and allow a photocopy of my signature to be used to file insurance. I also authorize and direct my insurer to issue payment check(s) for benefits due me for the services rendered by the above physicians regardless of my insurance benefits, if any. I understand I am financially responsible.

_____
date Patient (parent or guardian if minor)

Statement to permit payment of Medicare benefits: 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 the above named physician(s).

_____

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date Patient (parent or guardian if minor)

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 _____

Language

- ❑ English
- ❑ French
- ❑ German
- ❑ Vietnamese
- ❑ Italian
- ❑ Mandarin
- ❑ Spanish

Ethnicity

- ❑ Hispanic or Latino
- ❑ Non Hispanic or Latino Ethnicity

Referred by

- ❑ Primary Care Physician
- ❑ Patient Referral
- ❑ Yellow Pages
- ❑ Emergency Room
- ❑ Insurance Plan
- ❑ Former Patient
- ❑ Relative
- ❑ Friend
- ❑ Edward Referral
- ❑ Other _____

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Insurance and Billing Policy

1. Suburban Gastroenterology 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 your responsibility as a patient to contact your 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 if your have any objections with Midwest Endoscopy using these facilities.

2. Suburban Gastroenterology will call and verify insurance eligibility and request a "general description" of insurance benefits. It is **ultimately your responsibility as the patient** to you're your particular plan, as the insurance company will not guarantee payment of the benefits they quote.

3. For patients enrolled in the HMO or managed care products, Suburban Gastroenterology will contact the primary care physicians referral coordinator to "initiate" referrals for surgical procedures. It is your responsibility as a patient to follow through with the primary care office and have the referral "in hand" the day of your procedure.

4. Payment for insurance co-pays 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.

_____ _____

Patient's signature Date

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Consent for Release of Information for the Treatment, Payment and Health Care Operations

I, _____, hereby authorize Midwest Endoscopy Center 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, Midwest Endoscopy Center 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 Midwest Endoscopy Center 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 Midwest Endoscopy Center restricts how my individually identifiable health information is used and or disclosed to carry out treatment, payment or health operations. I understand that Midwest Endoscopy Center does not have to agree to such restrictions, but that once such restrictions are agreed to Midwest Endoscopy Center 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 _____

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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: _____ DOB: _____

Personal Representative: _____ Relationship: _____

It is the official policy of Midwest Endoscopy Center 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 Midwest Endoscopy Center and staff to leave medical information pertaining to my care by the following methods and will assume responsibility of notifying Midwest Endoscopy Center whenever this information changes.

Home Telephone ❑ Yes ❑ No

Answering Machine ❑ Yes ❑ No

Work Telephone # _____ ❑ Yes ❑ No

Voicemail ❑ Yes ❑ No

Cell phone/voicemail#_____ ❑ Yes ❑ No

Work Fax # _____ ❑ Yes ❑ No

Home Fax # _____ ❑ 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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Authorization for Release of Information

This form must be completed for ALL authorizations

I hereby authorize the use or disclosure of my protected health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Patient Name _____ Date of Birth _____

Organization releasing the information:

_____

_____

_____

Phone _____

Fax _____

Organization receiving the information:

_____

_____

_____

Phone _____

Fax _____

Specific description of the information (including date of healthcare) to be disclosed:

_____

_____

_____

_____

The patient or the patient's representative must read and initial the following statements:

1. I understand that this authorization will expire on ____/____/_____
   Initials: _____

2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing. Should I do so, this action will not have any affect on any actions taken by the providing organization before they received the revocation. Initials: _____

_____

Signature of patient or patient's representative Date

Printed name of patient's representative _____

Relationship to patient _____

You may refuse to sign this authorization

This form may not be used to release information for treatment or payment except when the information to be released is psychotherapy notes or certain research information.