MIDWEST
Endoscopy Center
healthy, for life

Doctors 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 Screening Packet

Dear Patient,

Please fill out the enclosed information packet and return this to our office within 1 week of your procedure. We are sending with your packet our new Patient link Card. This card enables us to easily capture your medical history, family history, social history and risk factors. This will allow us to have them recorded in your electronic medical record prior to your office visit with your physician. The form must be filled out with a #2 pencil.

When returning your packet please include a copy, both front and back, of your insurance cards (both primary and secondary carriers).

Please make sure this packet is completed and returned to our office within 1 week of your procedure.

Thank you,
The Doctors of Suburban Gastroenterology and Midwest Endoscopy Center

MIDWEST Endoscopy Center
healthy, for life

Payment Information

Billings

- **Facility services** are billed by Midwest Endoscopy Center
- **Professional physician services** are billed by Suburban Gastroenterology
- **Anesthesia services** are billed by Mobile Anesthesia, which can be contacted at 773.355.5300 for any billing concerns.
- **Pathology services** vary based on where the specimens are processed, which can be: Dianon Systems, Edward Hospital and Laboratory & Pathology Diagnostics LLC or Suburban Gastroenterology and/or GI Pathology

Payments

Either at the time your procedure is scheduled or via telephone before your scheduled date of service, an estimate of charges will be provided. This estimate is based on the average "allowable" amount, per your insurance carrier, for the baseline procedure being scheduled. The actual amount may be different depending on the exact procedure/technique performed, such as polyps removed and/or abnormal findings, etc.

We will swipe your credit/debit card and ask you to sign a receipt. This authorization will NOT result in charges to your card today. Your card is only charged after your health insurance company has paid their portion and provided the exact amount you owe.

Because the authorized amount is only an estimate, there is a chance the amount due may exceed the amount you had authorized. In that case we would charge the credit/debit card for the authorized amount and notify you of any remaining balance. The amount charged to your credit card will never exceed the amount authorized by you.

This payment process will not compromise your ability to dispute a charge or question your insurance company's determination of payment.

Eligibility

We will receive a quote of benefits and/or pre-certification/predetermination prior to your procedure(s); however, ultimately it is the patient's responsibility to also call their insurance to understand their benefits as they relate to their scheduled procedure(s). If an estimate has not been provided or if you have any questions or concerns, please call our billing department at 630.527.6450.

MIDWEST Endoscopy Center
healthy, for life

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).

_____
date Patient (parent or guardian if minor)

MIDWEST
Endoscopy Center
healthy, for life

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 _____

MIDWEST
Endoscopy Center
healthy, for life

Insurance and Billing Policy

1. Midwest Endoscopy 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. Midwest Endoscopy 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, Midwest Endoscopy 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

MIDWEST
Endoscopy Center
healthy, for life

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 _____

MIDWEST
Endoscopy Center
healthy, for life

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 _____

MIDWEST
Endoscopy Center
healthy, for life

Disclosure

Please review, sign and return to Midwest Endoscopy Center prior to your procedure

What we are: We are an endoscopy center licensed in the State of Illinois, and accredited By Medicare and AAAHC.

Who we are: We are owned by physicians Dinesh Jain, MD; Scott Berger, MD; Sushama Gundlapalli, MD and Darren Kastin, MD; and were developed to provide a safe and comfortable endoscopy facility that would provide efficient and effective services to patients.

Why we were opened: Outpatient care has been proven to increase patient comfort through personalized care while delivering quality services. Dinesh Jain, MD and Scott Berger, MD joined together to open Midwest Endoscopy Center to provide personal attention and quality services to their patients in and around DuPage County.

Your rights as a patient: You have the right to choose the provider and the facility for your health care services. You will not be treated differently by your physician if you obtain health care services at another facility.

Your choice: Your physician may have ownership interest in the Center. Please discuss with your gastroenterologist your questions or concerns, if you want to have your procedure at an alternative health care facility.

Credentials: All of the physicians and anesthesiologists have been credentialed according to AAAHC standards. Information is available upon request.

Patient grievances: If patients have complaints or concerns in regard to their care at Midwest Endoscopy Center, they are encouraged to fill out a grievance form which is available upon request at the front desk. Contact numbers are available now.

Malpractice Insurance: Your physician has malpractice insurance to meet the State of Illinois requirements or more.

Advance Directives: If you have an advance directive or living will, the Center will still transfer you to the closest hospital which will make decisions about following any advance directive or living will. You have a right to have your living will present in our medical record at the Center and to be informed of the Center's policy prior to the date of admission. State information and forms to prepare an advance directive, if you decide to have one, can be found at the following website: www.idph.state.il.us/public/books/advin.htm

Consumer Complaints for the IL Department of Health and Senior Services can be made at: www.dhs.state.il.us/page.aspx?item=27894

For Medicare: Offices of the Medicare Ombudsman at www.cms.hhs.gov/center/ombudsman.asp

I have received and read the above information

Patient Signature:_____ DOB: _____/_____/_____ Date:_____

Patient Print Name:_____Witness:_____ Date:_____

MIDWEST
Endoscopy Center
healthy, for life

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.