Michael D. Moseson, MD, FACS, FASCRS
Mark W. Dobriner, MD, FACS, FASCRS
Owen T. Su, MD, FACS, FASCRS
Lynn O'Connor, MD, MPH

Christine Kelly, RPA-C

Carole Romano
Administrator

Dear Patient:

We are pleased to welcome you back to Colon & Rectal Surgical, a Division of ProHEALTH Care Associates, LLP. Our doctors and staff members are dedicated to your health and well being and we appreciate the opportunity to participate in your medical care.

To make your visit to our office as pleasant and efficient as can be, we have enclosed some forms to assist you in providing us with some necessary information. This information will be used to ensure that we comply with your insurance carrier's requirements and will also assist the doctor in providing your care. Enclosed you will find your Registration form, History and Physical form and Financial Policy Agreement. **Please fill out all information on all the forms, sign where indicated, and bring them with you when you come for your appointment.**

If for any reason you need to change or cancel your appointment, please phone us as soon as possible so that we can accommodate you and/or other patients accordingly.

We thank you in advance for your cooperation and look forward to meeting you.

Sincerely yours,

The Physicians and Staff Members
of Colon & Rectal Surgical

3 Vermont Drive, Lake Success, N.Y. 11042
Tel: (516) 608-6848 • Fax (516) 570-4046

www.colonandrectalcare.com

200 W. Carver St., Suite 5, Huntington, N.Y. 11743
Tel: (631) 423-5070 • Fax (631) 423-5071

Welcome to Colon & Rectal Surgical
A Division of ProHEALTH Care Associates, LLP.

PATIENT REGISTRATION FORM

In order to serve you, we need the following information. Please print.

Today's Date:	Thank you for selecting ProHEALTH Care Associates.

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	Gender:	Age:	Birth Date:
Street Address:	Social Security No.:	Marital Status: S M D W SEP			
City/Town:	State:	Zip Code:	Home Phone No.:	Student: ☐ Part Time ☐ Full Time	
Mobile Phone No.:	Email Address:	Translator Needed? ______Yes _______No If yes, specify language________________________			
Employer:	Business Address:				
Work No.:	City/Town:	State:	Zip Code:		

SPOUSE'S INFORMATION

Last Name:	First:	Middle:	Gender:	Age:	Birth Date:
Mobile Phone No.:	Work No.:	Social Security No.:			
Employer:	Street Address:	City/Town:	State:	Zip Code:	

PARENT INFORMATION

Complete the section below with Parent's information if you are a full time student covered under your parent's health insurance.

Insured's Last Name:	Insured's First:	Middle:	Gender:	Age:	Birth Date:
Mobile Phone No.:	Work No.:	Social Security No.:			
Employer:	Street Address:	City/Town:	State:	Zip Code:	

EMERGENCY CONTACT

Name of Relative or Local Friend (not living at same address):	Relationship to Patient:
Primary Telephone No.:	Secondary Telephone No.:

PRIMARY CARE PHYSICIAN		REFERRING PHYSICIAN	
Primary Care Physician Name:		Referring Physician (if not same as PCP):	
Street Address:		Street Address:	
City, State, Zip:	Telephone No.:	City, State, Zip:	Telephone No.:

PHARMACY INFORMATION

Name of Pharmacy:	Address:	Telephone No.:
		Fax No.:

INSURANCE INFORMATION

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other:

PRIMARY INSURANCE	Insurance Name:	Claims Address:	Telephone No.:	Group No.: ID No.:
	Insured's Name (if not self, spouse or parent listed above):		Insured's S.S. No.:	Birth Date:

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other:

SECONDARY INSURANCE	Insurance Name:	Claims Address:	Telephone No.:	Group No.: ID No.:
	Insured's Name (if not self, spouse or parent listed above):		Insured's S.S. No.:	Birth Date:

AUTHORIZATION: RECEIPT OF AND RELEASE OF INFORMATION BY ProHEALTH Care Associates, LLP

I hereby authorize and direct the above named clinical practice, having treated me, to release to governmental agencies, insurance carriers, or others who are financially liable for my medical care, all information needed to substantiate payment for such medical care and to permit representatives thereof to examine and make copies of all records relating to such treatment. Upon my request for release of my medical records, I hereby authorize ProHEALTH Care Associates, LLP to furnish all records and results to the parties I specify. In addition, I have received biographical information about my doctor and all physicians practicing at CRS.

PATIENT SIGNATURE: ____________________________ DATE: ______/______/______

ASSIGNMENT OF BENEFITS

I hereby assign, transfer and set over to the above named clinical practice sufficient monies and/or benefits to which I may be entitled from government agencies, insurance carriers or others who are financially liable for my medical costs of the care and treatment rendered to myself or my dependent in said practice. I understand I am responsible for any services not covered by my insurance. I accept responsibility for payment of my account.

PATIENT SIGNATURE: ____________________________ DATE: ______/______/______

MedicalHistory_6_28_10.doc

NAME: ______________________ **DATE OF BIRTH:** ______________

Reason for Visit: ______________________

____

____

____

PLEASE INDICATE IF YOU HAVE HAD ANY OF THE FOLLOWING (CHECK ALL THAT APPLY)

- ❑ Rectal Bleeding ______________
- ❑ Diarrhea ______________
- ❑ Rectal Pain ______________
- ❑ Constipation ______________
- ❑ Itching/Burning______________
- ❑ Change in Bowel Habits ______________
- ❑ Protrusion/Swelling ______________
- ❑ Discharge ______________
- ❑ Fecal Incontinence ______________
- ❑ Abdominal Pain ______________
- ❑ Irritable Bowel Syndrome ______________
- ✶ How often do you move your bowels ______________
- ❑ Colonoscopy ______________ When ______________ Doctor ______________

PAIN ASSESSMENT

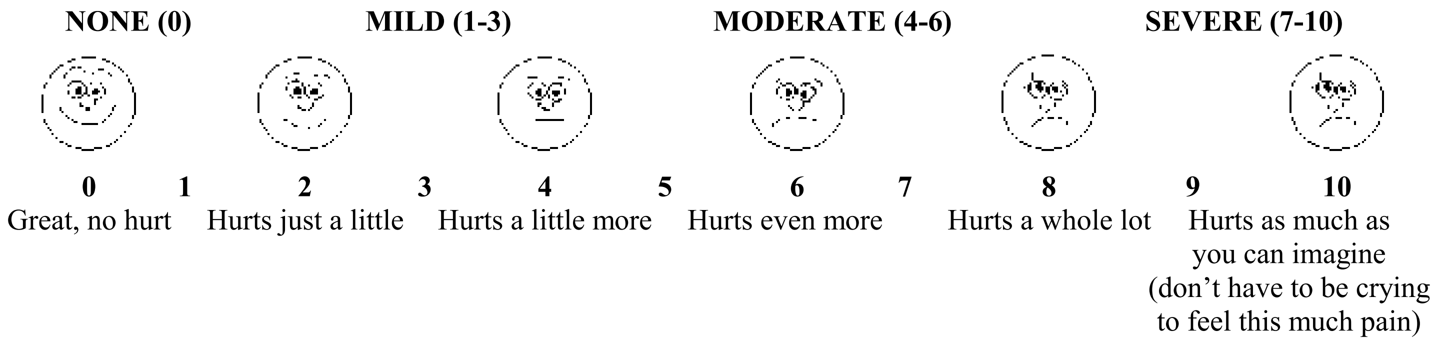
Please indicate **location** of pain, describe **quality and frequency** of pain, **circle #** that reflects degree of pain (even if no pain.)

LOCATION OF PAIN______________________

DESCRIBE PAIN ❑ Sharp ❑ Dull ❑ Burning ❑ Other ______________

❑ Always ❑ Sometimes ❑ ________x week ❑ With bowel movements ❑ Other: ______________

Use the chart below and circle the number that best describes the amount of pain (or lack of pain) you are feeling now:



LIST ALLERGIES (Medications / X-Ray Dye / Latex / Local Anesthesia, Etc.

____

____

CURRENT MEDICATIONS WITH DOSES (Prescription / Over The Counter / Vitamins / Nutritional Supplements

______________ ______________

______________ ______________

______________ ______________

______________ ______________

______________ ______________

Do you take antibiotics prior to surgical or dental procedures? YES ____ NO ____

Continued on Back

Dr's Initials: ______________

PROHEALTH CARE ASSOCIATES

CRS Colon & Rectal Surgical

Print Patient Name: ______________________________

PAST MEDICAL HISTORY / REVIEW OF SYSTEMS (CHECK ALL THAT APPLY)

- ❑ Colon Cancer ______________________
- ❑ Colon Polyps ______________________
- ❑ Diverticulosis ______________________
- ❑ Diverticulitis ______________________
- ❑ Ulcerative Colitis ______________________
- ❑ Crohn's Disease ______________________
- ❑ Anal or Rectal Surgery ______________________
- ❑ Heart Disease (Angioplasty, MI, etc.)______________________
- ❑ Heart Valve Disease ______________________
- ❑ Hypertension ______________________
- ❑ Heart Murmur: ______________________
- ❑ Pace Maker______________________
- ❑ Defibrillator ______________________
- ❑ Stroke______________________
- ❑ Sleep Apnea______________________
- ❑ Seizure Disease ______________________
- ❑ Neurological Disease: ______________________
- ❑ Lung Disease ______________________
- ❑ Liver Disease/Hepatitis ______________________
- ❑ Stomach Ulcer ______________________
- ❑ Kidney Disease ______________________
- ❑ Phlebitis ______________________
- ❑ Thyroid Disease ______________________
- ❑ Diabetes ______________________
- ❑ Bleed Easily ______________________
- ❑ Psychiatric ______________________
- ❑ Bladder Problem ______________________
- ❑ Prostate Problems ______________________
- ❑ Gynecological Problems ______________________
- ❑ Musculoskeletal/Prosthetic Joints: ______________________
- ❑ Vision/Hearing Problems______________________
- ❑ Personal History of Cancer______________________
- ❑ Any Chance of Pregnancy?______________________
- ❑ Date Last Menstrual Period: ______________________

FAMILY HISTORY / RELATIONSHIP-IE: MOTHER, FATHER ETC. (CHECK ALL THAT APPLY)

- ❑ Colon or Rectal Cancer ______________________
- ❑ Colon or Rectal Polyps______________________
- ❑ Crohn's Disease ______________________
- ❑ Ulcerative Colitis ______________________
- ❑ Other Cancer(s), Type ______________________

SOCIAL HISTORY

Do you use Tobacco? ❑ No ❑ Yes If Yes amount per day _________ ❑ Cigarettes or Cigars ❑ Smokeless Tobacco.

Do you drink Alcohol? ❑ No ❑ Yes If Yes, number of drinks _________ ❑ per week ❑ per day

SURGICAL HISTORY (List all with year performed)

____

____

____

____

____

HOSPITALIZATIONS (List all not shown to the left)

____

____

____

____

____

Prior Anesthesia Difficulties: ❑ Yes ❑ No

Blood Relatives w/Anesthesia Difficulties: ❑ Yes ❑ No

(X)______________________________ ______________

PATIENT SIGNATURE **DATE**

FOR NURSES/PHYSICIANS ONLY

VITAL SIGNS

B/P ___________ Pulse ___________ Height ___________ Weight ___________

FOR PHYSICIAN ONLY

EDUCATIONAL NEEDS ASSESSMENT

Any Barriers to Learning? ❑ **NO** ❑ **YES If YES, Areas of Need:** Check applicable:

❑ Language ❑ Cultural ❑ Cognitive ❑ Behavioral ❑ Post Procedure Care ❑ Medication Rxn ❑ Informed Consent. ❑ Post-Op Instruct.

Education Provided To: ❑ Patient ❑ Spouse ❑ Home Care Nurse ❑ Other: ______________________

______________________________ ______________________________

PHYSICIAN'S SIGNATURE **DATE**

OUR PRACTICE FINANCIAL POLICY

In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have any questions about this policy, please discuss them with our Billing Coordinator. We are dedicated to providing the best possible care and the highest level of service and regard your complete understanding of our financial responsibilities as an essential element of your care and treatment.

Unless other arrangements have been made in advance by either you or with your health insurance carrier, full payment is due at the time of service. For your convenience, we accept, CASH, CHECKS, VISA & MASTERCARD.

Medicare Patients:

- We are participating providers of Medicare. We will be collecting your 20% Medicare coinsurance and/or deductible (if applicable) at the time of your visit, **UNLESS** your secondary carrier is automatically "crossed-over" by Medicare. In that case, if your secondary carrier's reimbursement does not cover the co-insurance in full, you will be billed for the balance.
- If you have recently joined or are planning to join a Medicare HMO for your health insurance coverage, it is imperative that you let our office know as soon as possible. At this time we do not participate in any Medicare HMOs.

Managed Care Patients:

REFERRALS:

We have made prior arrangements with many insurers and other health plans to accept assignment of benefits and with whom we are participating providers. **The following requirements will need to be adhered to**:

- If a ***referral form*** or ***referral authorization*** is required, you must present it to the receptionist at the time of your initial appointment. If you are scheduled for follow up visits, **it is your responsibility to make sure that your ongoing referral is valid.**
- If you choose to use your benefits "out of network" (without a referral from your PCP), you will be responsible for any associated out of pocket expenses, which will be due at time of service. Questions can be directed to the Billing Manager.
- If you do not have out of network benefits and you opt to be seen without a referral authorization, you will be required to pay for the services in full.

CO-PAYMENTS:

- *Please be prepared to pay your co-payment/coinsurance at the time of your visit.*

PREVENTATIVE AND ROUTINE CARE:

Due to the nature of our specialty, we strongly advocate routine screenings and preventative care. Some managed care companies (depending on the type of contract negotiated by your employer group) will cover preventative services, while others do not. ***In the event that your contract does not cover these types of services, you will be responsible for payment.***

A NOTE ABOUT OUR FEES:

You may have been quoted a fee for your consultation or office visit. Please be aware that until the doctor examines you and discusses your medical needs, we cannot determine prior to your visit whether or not you will require any special diagnostic or therapeutic care during your visit. If you do require a diagnostic or therapeutic procedure, this service will be billed in addition to the fee for the office visit. Please feel free to ask questions about the care your doctor recommends.

It is the responsibility of the patient to know the terms of his or her insurance coverage. Please call your carrier if you have any questions about your benefits. Deductible or co-insurance amounts withheld from our payment are the responsibility of the patient. If you have any questions about this, please speak to our Billing Coordinator.

If we are denied payment due to lapse of coverage, misrepresented information provided to us at any time, failure to notify us of a change in your insurance information, or your failure to follow the rules of your insurance contract, you will be responsible for our regular fee.

I have read and understand the above stated financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended where necessary by the practice.

______________________________ ________________________

Signature of Patient **Today's Date**

____

Print Name

As a result of the Health Insurance Portability and Accountability Act (HIPAA), enforced by the US Department of Health and Human Services office of Civil Rights, we are not permitted to release patient information except as stated in the Notice of Privacy Practices, or in accordance with your wishes as stated below.

This waiver authorizes ProHEALTH Care Associates to send/give my medical information as noted:

Leave a voice mail recording including my Personal Health Information on my home/cell phone:
☐ Yes ☐ No

Leave a voice mail recording including my Personal Health Information on my business phone:
☐ Yes ☐ No

Use of electronic communication systems (i.e. fax, electronic messaging) to transmit prescription, treatment, disorder related information, lab or other results: ☐ Yes ☐ No

Use of email to transmit treatment or disorder related information which may include a diagnosis, lab or other results sent to me, even if the email is not encrypted (not protected over the Internet):
☐ Yes ☐ No

Permit the individual stated below (Personal Representative) to receive prescriptions and/or test results:
☐ Yes ☐ No

Speak to a family member of my choosing (Personal Representative) regarding my Personal Health Information:
☐ Yes ☐ No

Name of Personal Representative: ____

On this date ______________________, I received and reviewed ProHEALTH's Notice of Privacy Practices, which describes how my medical information may be used and disclosed and explains how I can get access to this information.

I had an opportunity to raise questions regarding this policy and all of my questions have been answered.

The authorizations made above will remain effective until such time as I notify ProHEALTH Care Associates in writing, by certified mail, of requested changes.

______________________________	______________________
Patient Name (Print)	Date of Birth
______________________________	______________________
Patient or Parent/Guardian Signature	Date
______________________________	______________________
Patient's Social Security Number	Email Address
______________________________	______________________
Home Address	Telephone Number

DIRECTIONS: TO OUR NEW LAKE SUCCESS OFFICE

3 VERMONT DRIVE – LAKE SUCCESS QUADRANGLE ~ LAKE SUCCESS, NY 11042
PHONE: (516) 608-6848 FAX (516) 570-4046

FROM THE NORTHERN STATE: Exit **25,** southbound, toward Lakeville Rd/New Hyde Park Rd, merging onto Lakeville Rd. Turn LEFT at Marcus Avenue. Take LEFT and Third Traffic Light into the Lake Success Quadrangle. At Stop Sign make RIGHT and travel to Vermont Drive. Make Left onto Vermont Drive.

WEST BOUND - LONG ISLAND EXPRESSWAY: Exit **34** to New Hyde Park Rd. Make Left onto New Hyde Park Rd. Make a Right at the second blue & gray Lake Success Quadrangle sign. Follow signs to "All Other Buildings" until you find Vermont Drive. Make left onto Vermont drive.

EAST BOUND – LONG ISLAND EXPRESSWAY: Exit **34** to New Hyde Park Rd. Make Right onto New Hyde Park Rd. Make a Right at the second blue & gray Lake Success Quadrangle sign. Follow signs to "All Other Buildings" until you find Vermont Drive. Make left onto Vermont drive.

For Map to the Lake Success Quadrangle, visit www.prohealthcare.com.

DIRECTIONS TO COLON & RECTAL SURGICAL: Huntington Office

200 WEST CARVER ST., SUITE 5, HUNTINGTON, NY 11743 (631) 423-5070

FROM THE NORTHERN STATE: EXIT 40N to merge onto RT-110 N toward HUNTINGTON. Travel approx.. 5.5 miles north bound. TURN LEFT at W. CARVER ST. (before 25A/No. Blvd.) Pass two Stop Signs. Building will be on your LEFT. Parking available in lot.

FROM THE LONG ISLAND EXPRESSWAY: EXIT 49N toward RT-110 N / HUNTINGTON Travel northbound on RT 110, approx. 6 mi. TURN LEFT at W. CARVER ST. (before 25A/ No. Blvd.) Pass two Stop Signs. Building will be on your LEFT. Parking available in lot.

ALTERNATE FROM NORTHERN STATE OR LIE: NORTHERN STATE to EXIT 42 N (DEER PARK AVE.) Or LIE/495 to EXIT 51 N (DEER PARK AVE.) Travel north bound on DEER PARK AVE, over RT 25 (Jericho Tpke.) Continue until you reach 25A/NORTHERN BLVD. Make LEFT on 25A/MAIN ST. Continue WEST and cross over RT 110 / NY AVE. At fourth traffic light make a LEFT onto PROSPECT AVE. Make RIGHT at the Stop Sign onto W. CARVER. Building is immediately to the left. Make LEFT into parking lot.

FROM NORTHERN BLVD. If traveling EAST BOUND, continue on 25A past the village of Cold Spring Harbor. The road will bend. The next town will be Huntington Village. Shortly after entering Huntington Village, make RIGHT onto PROSPECT AVE. (see Library) then make RIGHT at first Stop Sign onto W. CARVER. Building is immediately to the LEFT and make LEFT into Parking Lot.

NOTE: Building numbers do not run consecutively on West Carver
Follow directions above and you can't miss it!