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Dear Patient:

We are pleased to welcome you 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 the forms, sign where indicated, and bring them with you when you come for your appointment.**

Please bring with you a list of all your medications with doses for all prescribed and over the counter medications, supplements, herbs, and ointments.
(You may ask your pharmacist or your primary care doctor for a copy of your medication list.)

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
A Division of ProHEALTH Care Associates, LLP

NAME: _____ DATE OF BIRTH: _____

Reason for Visit: _____

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

- | | |
|---|---|
| <input type="checkbox"/> Rectal Bleeding _____ | <input type="checkbox"/> Protrusion/Swelling _____ |
| <input type="checkbox"/> Diarrhea _____ | <input type="checkbox"/> Discharge _____ |
| <input type="checkbox"/> Rectal Pain _____ | <input type="checkbox"/> Fecal Incontinence _____ |
| <input type="checkbox"/> Constipation _____ | <input type="checkbox"/> Abdominal Pain _____ |
| <input type="checkbox"/> Itching/Burning _____ | <input type="checkbox"/> Irritable Bowel Syndrome _____ |
| <input type="checkbox"/> Change in Bowel Habits _____ | * How often do you move your bowels _____ |
| <input type="checkbox"/> Colonoscopy _____ When _____ | Doctor _____ |

PAIN ASSESSMENT

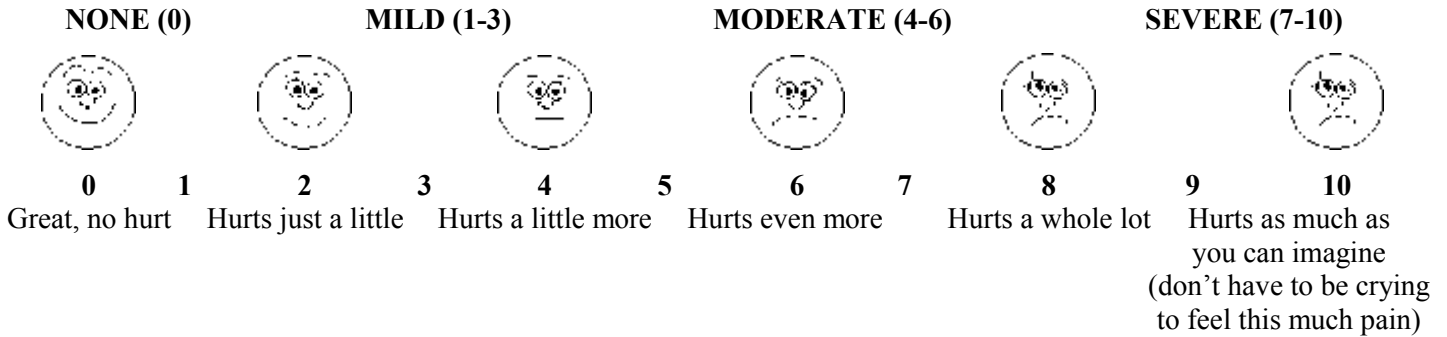
Please indicate **location** of pain, describe **quality and frequency** of pain, **circle #** that reflects degree of pain (even if no pain.)

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 _____

Print Patient Name: _____

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

- | | |
|--|---|
| <input type="checkbox"/> Colon Cancer _____ | <input type="checkbox"/> Lung Disease _____ |
| <input type="checkbox"/> Colon Polyps _____ | <input type="checkbox"/> Liver Disease/Hepatitis _____ |
| <input type="checkbox"/> Diverticulosis _____ | <input type="checkbox"/> Stomach Ulcer _____ |
| <input type="checkbox"/> Diverticulitis _____ | <input type="checkbox"/> Kidney Disease _____ |
| <input type="checkbox"/> Ulcerative Colitis _____ | <input type="checkbox"/> Phlebitis _____ |
| <input type="checkbox"/> Crohn's Disease _____ | <input type="checkbox"/> Thyroid Disease _____ |
| <input type="checkbox"/> Anal or Rectal Surgery _____ | <input type="checkbox"/> Diabetes _____ |
| <input type="checkbox"/> Heart Disease (Angioplasty, MI, etc.) _____ | <input type="checkbox"/> Bleed Easily _____ |
| <input type="checkbox"/> Heart Valve Disease _____ | <input type="checkbox"/> Psychiatric _____ |
| <input type="checkbox"/> Hypertension _____ | <input type="checkbox"/> Bladder Problem _____ |
| <input type="checkbox"/> Heart Murmur: _____ | <input type="checkbox"/> Prostate Problems _____ |
| <input type="checkbox"/> Pace Maker _____ | <input type="checkbox"/> Gynecological Problems _____ |
| <input type="checkbox"/> Defibrillator _____ | <input type="checkbox"/> Musculoskeletal/Prosthetic Joints: _____ |
| <input type="checkbox"/> Stroke _____ | <input type="checkbox"/> Vision/Hearing Problems _____ |
| <input type="checkbox"/> Sleep Apnea _____ | <input type="checkbox"/> Personal History of Cancer _____ |
| <input type="checkbox"/> Seizure Disease _____ | <input type="checkbox"/> Any Chance of Pregnancy? _____ |
| <input type="checkbox"/> Neurological Disease: _____ | <input type="checkbox"/> Date Last Menstrual Period: _____ |

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

- | | |
|---|---|
| <input type="checkbox"/> Colon or Rectal Cancer _____ | <input type="checkbox"/> Crohn's Disease _____ |
| <input type="checkbox"/> Colon or Rectal Polyps _____ | <input type="checkbox"/> Ulcerative Colitis _____ |
| <input type="checkbox"/> 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!