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Dear Patient:

We are pleased to welcome you to Colon & Rectal Surgical Associates of Long Island, P.C. 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 Assoc. of L.I., P.C.



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



Colon & Rectal Surgical Associates of LL
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: <input type="checkbox"/> Part Time <input type="checkbox"/> Full Time		
Mobile Phone No.:		Email Address:			Translator Needed? <input type="checkbox"/> Yes <input type="checkbox"/> 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.:			

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"/> Rectal Pain _____ | <input type="checkbox"/> Fecal Incontinence _____ |
| <input type="checkbox"/> Diarrhea _____ | <input type="checkbox"/> Discharge _____ |
| <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 _____ | <input type="checkbox"/> ★ How often do you move your bowels _____ |
| <input type="checkbox"/> Colonoscopy _____ When _____ Doctor _____ | |

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 smoke? Yes ___ No ___ Packs Per Day _____ Do you drink alcohol? Yes ___ No ___ Drinks Per Day _____

CURRENT MEDICATIONS (Prescription / Over The Counter / Vitamins / Nutritional Supplements)

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

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

SURGICAL HISTORY (List all operations and year performed)

HOSPITALIZATIONS (List all not shown above)

Prior Anesthesia Difficulties: Yes No

Blood Relatives w/Anesthesia Difficulties: Yes No

PAIN ASSESSMENT

If you have pain, describe **location of pain** and using the scale below, please indicate your **level of pain** at this time:

LOCATION OF PAIN

NONE (0)



0

Great, no hurt

MILD (1-3)



2

Hurts just a little



4

Hurts a little more

MODERATE (4-6)



6

Hurts even more



8

Hurts a whole lot

SEVERE (7-10)



10

Hurts as much as you can imagine (don't have to be crying to feel this much pain)

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

- Language
- Cultural
- Cognitive
- Behavioral
- Post Procedure Care

If YES, Areas of Need: Check applicable:

- Medication Reaction
- Pre-Op / Post Op Instruction
- Medication Reaction
 - Informed Consent
 - Other: _____

Education Provided To:

- Patient
- Spouse
- Home Care Nurse
- Other: _____

PHYSICIAN'S SIGNATURE

DATE



FINANCIAL POLICY

In order to facilitate understanding between our patients and the Practice, we have adopted the following financial policy. Any questions you may have can be discussed 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, MASTERCARD, VISA, AMERICAN EXPRESS & DISCOVER.

Medicare Patients:

- We are participating providers of Medicare. You are responsible for the 20% Medicare coinsurance and/or deductible (if applicable), **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.

Managed Care Patients:

REFERRALS:

We are participating providers with many insurers. **The following requirements will need to be adhered to:**

- If a ***referral form*** or ***referral authorization*** is required, you must obtain it and 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 at the time of visit.

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 Collecting Balance Due from Patients

As a ProHEALTH Care medical practice, we may ask you to satisfy a balance due that remains in your account for services rendered by another ProHEALTH Care physician in a different location from those occupied by CRSA. If you have questions about those bills or our request for payment, our Billing Coordinator will assist and/or work with you to contact the Billing Coordinator for the ProHEALTH Care practice that generated the bill.

A NOTE ABOUT OUR FEES:

You may have been quoted a fee for your consultation or office visit; however, 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. Additionally, if we perform a surgical proceed outside our office, you may have an out of pocket expense associated with the fees from the Hospital or Ambulatory Surgical Facility. 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, 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 Attesting to Understanding & Compliance with Policy

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 COLON & RECTAL SURGICAL ASSOC. OF L.I., P.C.: Great Neck Office

60 CUTTER MILL ROAD – SUITE 507 – Ph: (516) 487-8738

FROM THE LONG ISLAND EXPRESSWAY:

EXIT 33 NORTH (LAKEVILLE ROAD). Take Lakeville Rd north bound and cross over NORTHERN BLVD. Lakeville Rd. then becomes SOUTH MIDDLENECK ROAD.
Go approximately 5 traffic lights to CUTTERMILL ROAD (just after LIRR overpass)
Make LEFT onto CUTTERMILL ROAD.
Office Building is on the LEFT (with a Capital One Bank sign)

FROM THE NORTHERN STATE:

EXIT 25N (LAKEVILLE ROAD). Take Lakeville Rd. northbound and go under LIE.
Cross over NORTHERN BLVD.
Lakeville Rd. then becomes SOUTH MIDDLENECK ROAD.
Go approximately 5 traffic lights to CUTTERMILL ROAD (just after LIRR overpass)
Make LEFT onto CUTTERMILL ROAD.
Office Building is on the LEFT (with a Capital One Bank sign)

DIRECTIONS TO COLON & RECTAL SURGICAL ASSOC. OF L.I., P.C.: Huntington Office

200 West Carver St., 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.)
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.)
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/NORTHER BLVD onto MAIN STREET into the heart of the town of Huntington.
After SECOND TRAFFIC LIGHT make LEFT ON PROSPECT.
Make RIGHT onto W. CARVER and LEFT into Parking Lot.

FROM NORTHERN BLVD.

If traveling east bound, continue past Cold Spring Harbor. Shortly after entering Huntington Village, make RIGHT onto PROSPECT AVE. (see Library) then RIGHT onto W. CARVER and LEFT into Parking Lot.

If traveling westbound, go past RT 110. After second light, make LEFT onto PROSPECT AVE (see Library) then RIGHT onto W. CARVER and LEFT into Parking Lot.