



Colon & Rectal Surgical Associates of L.L, P.C.

Today's Date: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Mid. Intl: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Email: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Bus Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_ Social Security #: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Spouse's Full Name: \_\_\_\_\_

Fathers' First Name: \_\_\_\_\_ Mother's First Name: \_\_\_\_\_

Your Occupation: \_\_\_\_\_ Employer's Name: \_\_\_\_\_

Employer's Address and Phone: \_\_\_\_\_

Spouse/Parent Employer Name,Address,Phone: \_\_\_\_\_

Emergency Contact: Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

What is your primary language: \_\_\_\_\_ Do you need a translator? \_\_\_\_\_

Which physician referred you to this practice? (Name, Address, Phone) \_\_\_\_\_

Who is your primary care physician: (Name, Address, Phone) \_\_\_\_\_

Any other doctors treating you at this time: \_\_\_\_\_

I authorize the following people to have to have access to my medical information:

\_\_\_\_\_ Relationship: \_\_\_\_\_ \_\_\_\_\_ Relationship: \_\_\_\_\_

\_\_\_\_\_ Relationship: \_\_\_\_\_ \_\_\_\_\_ Relationship: \_\_\_\_\_



**Primary Insurance Carrier:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

Policy Holder Relationship to You: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

SS# \_\_\_\_\_

Policy ID# \_\_\_\_\_ Group # \_\_\_\_\_

**Secondary Insurance Carrier**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

Policy Holder Relationship to You: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

SS# \_\_\_\_\_

Policy ID# \_\_\_\_\_ Group # \_\_\_\_\_

I understand that unless other arrangements are made in advance or where applicable federal or state laws supersede, all fees are the responsibility of the patient and are due at the time of service.

I authorize release of any medical or other information necessary to process medical claims for professional services rendered by this office and its health care providers.

I authorize the release of any of my medical information to any of my other doctors to ensure quality care, as well as those individuals I have listed above as authorized to have access to my medical information.

I have received biographical information about my doctor and all physicians at CRSA.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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 _____ | * 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"/> Pace Maker _____                            | <input type="checkbox"/> Prostate Problems _____          |
| <input type="checkbox"/> Defibrillator _____                         | <input type="checkbox"/> Gynecological Problems _____     |
| <input type="checkbox"/> Seizure/Stroke _____                        | <input type="checkbox"/> Personal History of Cancer _____ |

**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 _____  |   |

**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)**

_____	_____
_____	_____
_____	_____

**CONTINUE ON BACK OF SHEET**

**HOSPITALIZATIONS (List all not shown above)**






\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**SOCIAL HISTORY**

Do you smoke? Yes \_\_\_ No \_\_\_ Packs Per Day \_\_\_\_\_ Do you drink alcohol? Yes \_\_\_ No \_\_\_ Drinks Per Day \_\_\_\_\_

**PAIN ASSESSMENT**

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

<b>NONE (0)</b>	<b>MILD (1-3)</b>	<b>MODERATE (4-6)</b>	<b>SEVERE (7-10)</b>
			
0	2	4	6
Great, no hurt	Hurts just a little	Hurts a little more	Hurts even more
			8
			
			10
			Hurts as much as you can imagine (don't have to be crying to feel this much pain)

**PATIENT SIGNATURE** \_\_\_\_\_

**DATE** \_\_\_\_\_

**\*\*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** \_\_\_\_\_

**Physician's Post 30 Day Reassessment (Note: Complete new med hx needed if over 60 days old)**

- No Changes in Medical History, Pain, or Educational Assessment
- Changes as follows: \_\_\_\_\_

## 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.**

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Signature of Patient

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Today’s Date

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Print Name



*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.