SUBURBAN GASTROENTEROLOGY

DINESH JAIN, M.D.
SCOTT BERGER, M.D.
SUSHAMA GUNDLAPALLI, M.D.
DARREN KASTIN, MD
RAVI NADIMPALLI, M.D.
GONZALO PANDOLFI, M.D.
SHIVANI KIRILUK, D.O.

1243 Rickert Dr.
Naperville, IL 60540

Telephone 630-527-6450
Fax 630-527-6456

Suburban Gastroenterology, Ltd. would like to welcome you and confirm your appointment.

DAY: _____

DATE: _____

ARRIVAL TIME: _____

PLACE: **Suburban Gastroenterology**
1243 Rickert Dr.
Naperville, IL 60540

Enclosed is a map for your information regarding location.

Please bring with you a list of current medications you are taking and any records or tests that pertain to the reason you are seeing the physician: i.e. upper GI x-rays, any recent blood work, Ultrasounds, or CT scans. We will also need you to bring your insurance card. If your insurance is an HMO, POS, EPO or managed care plan, please remember your authorization number or referral. All copays, deductibles and non-insured patients will be expected to make payment at the time of service.

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.

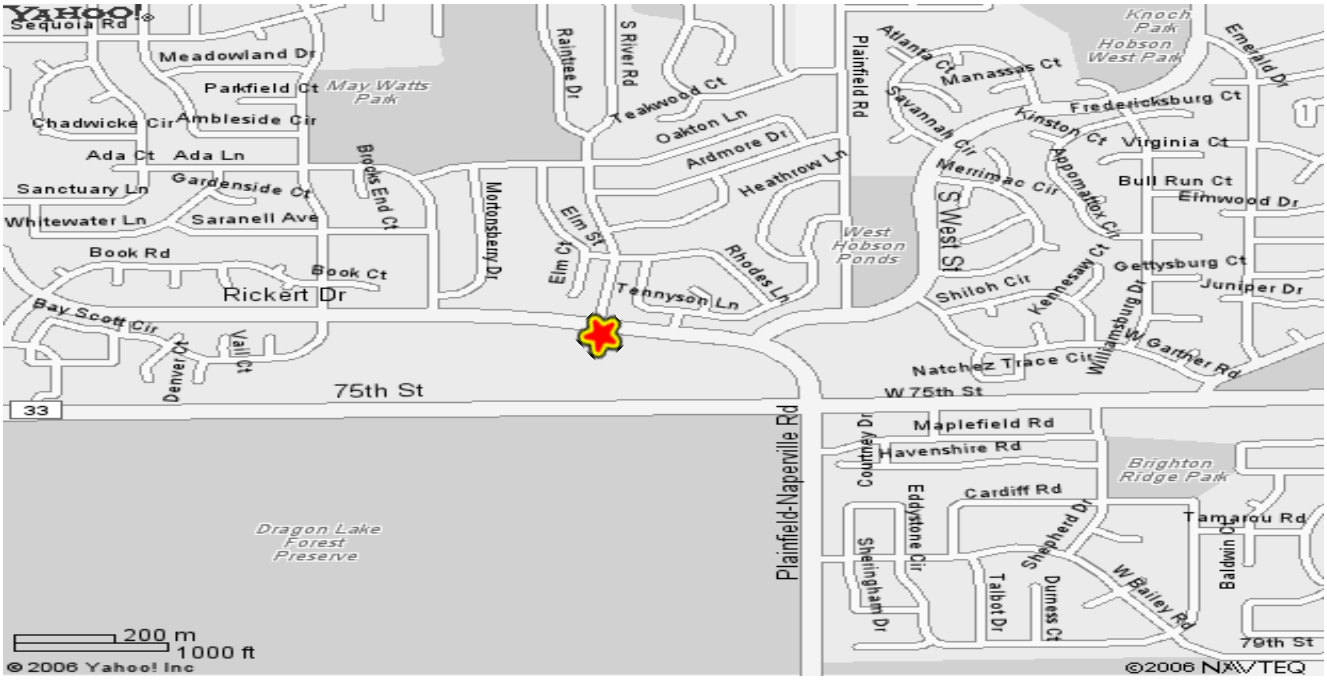
We ask that you complete the enclosed registration form, link card, and sign where indicated. Please bring these forms with you on your appointment date.

Because of the number of patients waiting to receive medical care, we need to insure that all available appointments are used. In the event that you are unable to keep your appointment, please notify us at (630) 527-6450 within two working days so that we may offer your time to another patient.

Thank you for choosing Suburban Gastroenterology, Ltd. We look forward to serving your patient care needs.

* **As a courtesy to other patients, if you can not arrive on time, you may have to be rescheduled. Also, if you arrive earlier than the stated arrival time, please know you may be waiting for a longer period of time.**

Suburban Gastroenterology and Midwest Endoscopy



1243 Rickert Drive
Naperville, IL 60540
Phone: (630) 527-6450

From the North
I-355 South
Exit 75th Street
Turn Right (heading West) on 75th Street to
Rickert Drive (same road as Plainfield/Naperville Road)
Turn Right at stoplight for Rickert Drive
Turn Left at side street – River Road

From the South
Rt. 53 North
Turn Left (heading West) on 75th Street to
Rickert Drive (same road as Plainfield/Naperville Road)
Turn Right at stoplight for Rickert Drive
Turn Left at side street – River Road

From the East
Ogden Ave (Rt. 34) West
Turn Left on Rickert Drive
Turn Right on side street – River Road

From the West
I-88 East
Exit Rt. 59 Turn Right (South)
Take Rt. 59 to Ogden Ave. (Rt. 34)
Turn Left on Ogden Ave (Rt. 34) to Rickert Drive
Turn Right on Rickert Drive
Turn Right on side street – River Road

*** PLEASE PRINT ***

PATIENT REGISTRATION

PATIENT NAME_____ DOB_____AGE_____ □ MALE □ FEMALE
FIRST INITIAL LAST

PATIENT SOCIAL SECURITY# _____ PHONE (HOME) _____ MARITAL STATUS
□ S □ M □ W □ D

PHONE (WORK) _____ PHONE (CELL) _____

PATIENT ADDRESS _____
STREET CITY STATE ZIP COUNTY

PATIENT EMAIL ADDRESS _____

PATIENT PRIMARY CARE PHYSICIAN _____ PATIENT REFERRING PHYSICIAN _____

PATIENT'S EMPLOYER _____

EMPLOYER ADDRESS _____ EMPLOYER PHONE # _____

EMERGENCY CONTACT _____RELATIONSHIP _____

EMERGENCY CONTACT PHONE (HOME) _____ EMERGENCY CONTACT (WORK) _____

DO YOU HAVE ADVANCED DIRECTIVES (i.e. living will): _____

INSURANCE INFORMATION: (NEEDED IN ORDER TO FILE YOUR CLAIM)

PRIMARY INSURANCE COMPANY _____

IDENTIFICATION NUMBER _____GROUP NUMBER _____

ADDRESS OF INSURANCE COMPANY _____ CITY_____ STATE_____Z IP_____

POLICY HOLDER NAME (if other than patient) _____RELATIONSHIP _____

POLICY HOLDER DOB _____ POLICY HOLDER SOCIAL SECURITY NUMBER _____

POLICY HOLDER PLACE OF RETIREMENT _____

SECONDARY INSURANCE COMPANY _____

IDENTIFICATION NUMBER _____GROUP NUMBER _____

ADDRESS OF INSURANCE COMPANY _____ CITY _____ STATE _____ ZIP _____

POLICY HOLDER NAME (if other than patient) _____RELATIONSHIP _____

POLICY HOLDER DOB _____ POLICY HOLDER SOCIAL SECURITY NUMBER _____

POLICY HOLDER PLACE OF RETIREMENT _____

PATIENT'S AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND CLAIM PAYMENT AUTHORIZATION; I HEREBYAUTHORIZE THE ABOVE PHYSICIAN(S) TO RELEASE ANY INFORMATION REGARDING SERVICES RENDERED BY THE PHYSICIAN AND ALLOW A PHOTOCOPY OF MY SIGNATURE TO BE USED TO FILE INSURANCE. I ALSO HEREBY AUTHORIZE AND DIRECT MY INSURER TO ISSUE PAYMENT CHECK (S) FOR BENEFITS DUE ME FOR THE SERVICES RENDERED BY THE ABOVE NAMED PHYSICIAN(S) TO BE MADE DIRECTLY TO THE PHYSICIAN REGARDLESS OF MY INSURANCE BENEFITS, IF ANY. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR THE FEES FOR SERVICES RENDERED.

_____
DATE PATIENT (PARENT OR GUARDIAN IF MINOR)

STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER, PHYSICIAN AND PATIENT; 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 TO THE ABOVE NAMED PHYSICIAN(S).

_____
DATE PATIENT (PARENT OR GUARDIAN IF MINOR)

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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
- ☐ Other _____

REFERRED BY:

- ☐ Primary Care Physician
- ☐ Patient Referral
- ☐ Yellow Pages
- ☐ Emergency Room
- ☐ Insurance Plan
- ☐ Former Patient
- ☐ Relative
- ☐ Friend
- ☐ Edward Referral
- ☐ Other

ETHNICITY:

- ☐ Hispanic or Latino
- ☐ Non Hispanic or Latino Ethnicity
- ☐ Unknown

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Insurance and Billing Policy

1. Suburban GI 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 the patient's responsibility to contact their 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 the patient has any objections with Suburban GI using these facilities.

2. Suburban GI will call and verify insurance eligibility and request a "general description" of insurance benefits. It is **ultimately the responsibility of the patient** to know their particular plan, as the insurance company will not guarantee payment of the benefits they quote.

3. For those patients enrolled in the HMO or managed care products, Suburban GI will contact the primary care physicians referral coordinator to "initiate" referrals for surgical procedures. It is the patient's responsibility to follow through with the primary care office and have the referral "in hand" the day of the procedure.

4. Payment for insurance copays 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 Signature Date

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CONSENT FOR RELEASE OF INFORMATION FOR THE TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I, _____, hereby authorize Suburban Gastroenterology, Ltd. 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, Suburban Gastroenterology, Ltd. 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 Suburban Gastroenterology, Ltd. 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 Suburban Gastroenterology, Ltd. restricts how my individually identifiable health information is used and or disclosed to carry out treatment, payment or health operations. I understand that Suburban Gastroenterology, Ltd. does not have to agree to such restrictions, but that once such restrictions are agreed to Suburban Gastroenterology, Ltd. 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

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 office policy of Suburban Gastroenterology, LLC 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 Suburban Gastroenterology, LLC and staff to leave medical information pertaining to my care by the following methods and will assume responsibility of notifying Suburban Gastroenterology, LLC whenever this information changes.

Home Telephone	_____YES	_____NO
Answering Machine	_____YES	_____NO
Work Telephone, Number _____	_____YES	_____NO
Voicemail:	_____YES	_____NO
Cell phone/Voicemail # _____	_____YES	_____NO
Work Fax Number _____	_____YES	_____NO
Home Fax Number _____	_____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: _____