SUBURBAN GASTROENTEROLOGY

DINESH JAIN, M.D.
SCOTT BERGER, M.D.
SUSHAMA GUNDLAPALLI, M.D.
DARREN KASTIN, MD
GONZALO PANDOLFI, M.D.
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ADITYA DHOLAKIA, D.O.

1243 Rickert Drive
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 Drive
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 Medical History Form. 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.

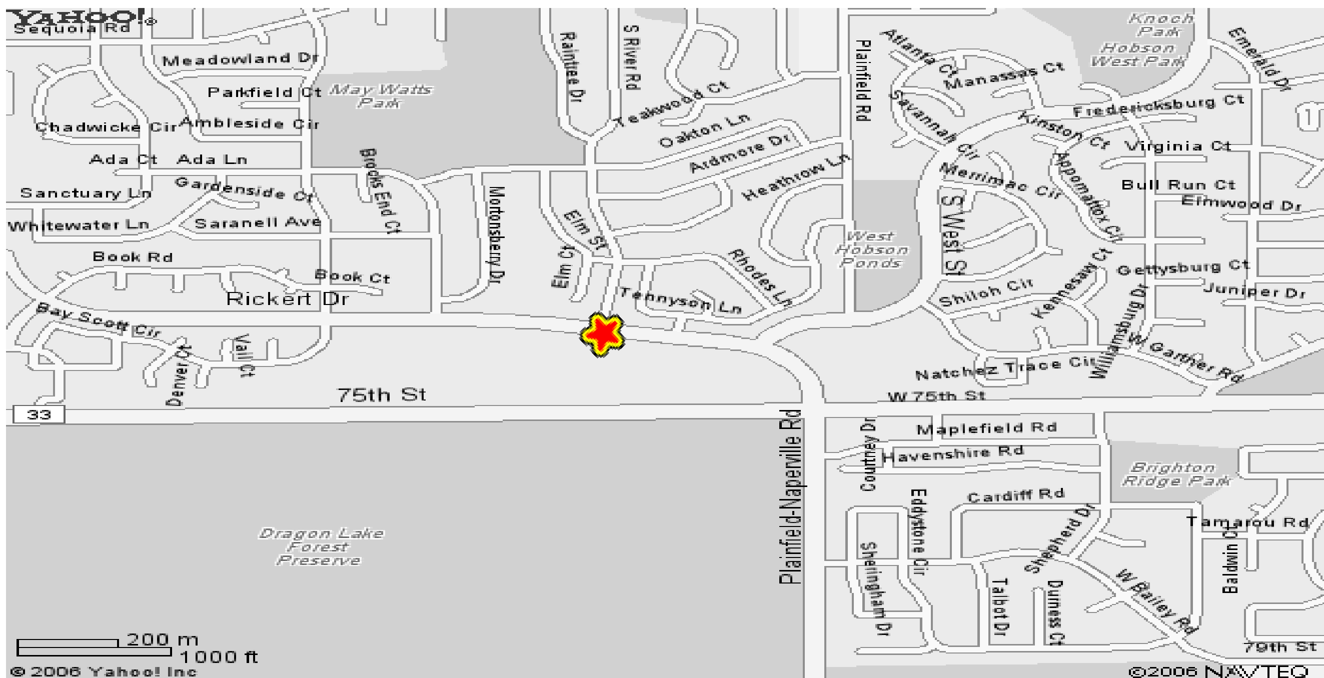
We ask that you complete the enclosed registration packet, and sign where indicated. Please bring these forms with you on your appointment date.

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

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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 will be read by our in house pathologist which will be billed by Suburban Gastroenterology, LTD. All second opinions will be submitted to Edward Hospital pathology, 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. **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

3. 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.

4. 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.

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.

____ _______________________
Name of Patient DOB

____ _______________________
Signature of Patient or Legal Representative (if applicable) Date

____
Name of Legal Representative and relationship to patient (if applicable)

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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.

______________________________________ ______________________
Name of Patient DOB

______________________________________ ______________________
Signature of Patient or Legal Representative (if applicable) Date

____
Name of Legal Representative and relationship to patient (if applicable)

SUBURBAN GASTROENTEROLOGY, LTD

MIDWEST ENDOSCOPY CENTER, LLC

CONSENT TO RELEASE OF HEALTH INFORMATION

It is the policy of Suburban Gastroenterology, Ltd. and Midwest Endoscopy Center, LLC (collectively, the "Practice") not to release information about your medical care, condition and/or test results via telephone, e-mail, answering machine/voice mail, cellular phone or fax, or to certain third-parties, without your permission.

Please select whether we may contact you by any of the following methods. ***By making a selection, you give the Practice permission to share information with you regarding your medical care, condition and/or test results through the methods selected below*** (select all that apply and provide the requested information):

May we contact you via your home telephone # ______________________? ____YES ____NO
May we leave messages on your home telephone answering machine/voicemail? ____YES ____NO
May we contact you via your work telephone # _______________________? ____YES ____NO
May we leave messages on your work telephone answering machine/voicemail? ____YES ____NO
May we contact you via your cellular telephone # _____________________? ____YES ____NO
May we leave messages on your cellular telephone voicemail? ____YES ____NO
May we contact you via fax # ______________________________________? ____YES ____NO
May we contact you via e-mail address _____________________________? ____YES ____NO
May we contact you via Mychart? ____YES ____NO
(Please note that notification of portal messages are sent to your e-mail address you provide)

If information regarding your medical care, condition and test results can be released to someone other than yourself, please complete the following:

Name: ___________________________________ Relationship: ___________________________________

Name: ___________________________________ Relationship: ___________________________________

By signing below, I acknowledge that it is my responsibility to update the Practice of any changes to the contact information set forth above. My authorizations will remain in effect until terminated by me in writing, which I may do at any time; however, I understand that my revocation will not affect any communications made prior to such revocation. I acknowledge that the Practice cannot ensure the security of electronic communications and messages, including, but not limited to, the use of unencrypted e-mail. I understand that the content of this consent does not prevent the Practice from disclosing information about my medical care, condition and/or test results for treatment, payment or health care operation or as otherwise allowed by law, and my consent will not be specifically required for those purposes.

____ _________________________
Name of Patient DOB

____ _________________________
Signature of Patient or Legal Representative (if applicable) Date

____
Name of Legal Representative and relationship to patient (if applicable)

MIDWEST ENDOSCOPY CENTER, LLC.

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MIDWEST ENDOSCOPY CENTER

Appointment Policy

At Midwest Endoscopy Center, LLC., we put our faith in you to keep your appointment. Many offices double book appointments to prevent from being financially damaged as a result of a missed appointment. We choose to not do this. We prefer to give the appropriate care and attention to each patient and provide excellent care.

If for any reason you must cancel or change your Midwest Endoscopy Center procedure appointment, it is important that you give our office **at least three business days' notice** to offer that procedure time to someone else. If you fail to do this, there will be a **$100.00** fine assessed.

We understand that true emergencies do occur. Under these circumstances a doctor's note or other appropriate documentation will be considered to have the charge waived.

_______________________________________ ____________________

Name of Patient **DOB**

_______________________________________ ____________________

Signature of Financially Responsible Party **Date**

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SUBURBAN GASTROENTEROLOGY

Appointment Policy

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If for any reason you must cancel or change your Suburban Gastroenterology office appointment, it is important that you give our office **at least two business days' notice** to offer that appointment to someone else. If you fail to do this, there will be **a $50.00 fine** assessed.

We understand that true emergencies do occur. Under these circumstances a doctor's note or other appropriate documentation will be considered to have the charge waived.

_______________________________________ _______________________

Name of Patient **DOB**

_______________________________________ _______________________

Signature of Financially Responsible Party **Date**

SUBURBAN GASTROENTEROLOGY, LTD

1243 Rickert Drive, Naperville, IL 60540 Telephone 630-527-6450 Fax 630-527-6456

Patient Name: ____ **DOB:** ______________________

Weight: __________________ **Height:** __________________

ALLERGIES TO MEDICATIONS: ____

ALLERGIES TO FOODS: ____

MEDICAL HISTORY: (Circle all that apply)

Gastrointestinal

-Abdominal distention
-Abdominal pain
-Belching
-Black Stools
-Bloating
-Blood in stool
-Constipation
-Diarrhea
-Food/Milk Intolerance
-Gas/Flatulence
-Get full quickly at meals
-Hemorrhoids
-Hernia
-Incontinence of stool
-Indigestion
-Irregular bowel habits
-Jaundice
-Laxative Use
-Nausea
-Pain with bowel movements
-Painful swallowing
-Swallowing problems
-Vomiting
-Vomiting Blood

General

-Fatigue
-Fever
-Loss of appetite
-Night sweats
-Sleep disturbance
-Weight gain
-Weight loss

Neurological

-Dementia
-History of Stroke
-Recent dizziness
-Recent passing out
-Seizures

Cardiovascular

-Automatic Defibrillator
-Chest Pain or Pressure - after eating or when upset
-Chest Pain or Pressure with exertion (angina)
-High cholesterol
-History of heart murmur
-History of rheumatic fever
-Irregular heart - rate/palpitations
-Leg swelling
-Other implanted devices
-Pacemaker
-Stents

Respiratory

-Chronic Cough
-Chronic or frequent hoarseness
-Cough up sputum
-Exposure to tuberculosis
-Shortness of breath
-Sleep apnea
-Spitting up blood
-Wheezing

Genitourinary

-Blood in urine
-Frequent urinary infections
-Frequent urination
-History of kidney stones
-Kidney Failure
-Leaking urine
-Painful/difficult urination

Endocrine

-Diabetes mellitus
-Thyroid disease

Psychosocial

-Anxiety
-History of depression
-History of eating -disorder
-History of mental illness
-History of physical or sexual abuse
-Stress
-Usually feel lonely or depressed

Skin

-Body piercing
-Change in hair or nails
-Flushing
-Rash
-Severe itching
-Tattoos
-Unusual moles

Bone & Joint

-Arthritis
-Back pain
-Joint pain
-Osteoporosis

Blood

-Anemia
-Easy bruising
-Enlarging or painful lymph nodes
-Excessive bleeding

Eyes

-Blurred/double vision
-Eye Disease
-Glasses or contacts
-Glaucoma

Ear/Nose/Throat

-Bad breath or bad taste in mouth
-Hearing loss
-Mouth sores
-Nose or gums bleeding

SURGICAL HISTORY: (CIRCLE)

-Angioplasty
-Aortic aneurysm
-Appendectomy
-Back surgery
-Bowel resection
-CABG
-Cholecystectomy-Colon resection
-Colon resection w/colostomy
-Colonoscopy
-EGD
-ERCP
-Flexible Sigmoidoscopy
-Gastric Bypass
-Heart valve
-Hemorrhoidectomy
-Hernia surgery
-Hip replacement
-Knee replacement surgery
-Liver biopsy
-Lysis of adhesions
-Pacemaker
-Prostatectomy
-Spine
-Thyroidectomy
-Tonsillectomy
-Transplant

Family History

	Relationship to the patient: **(Please list if maternal or paternal side of the family)**
Colon Cancer	
Breast Cancer	
Ovarian Cancer	
Uterine Cancer	
Prostate Cancer	
Crohn's Disease	
Ulcerative Colitis	
Bleeding Disorder	
Colon Polyps	
Alcohol and other disorders associated	
Diabetes	
Hypertension	
Heart Attack	
Stroke	
Sickle Cell	
Mental Disorder	

Other: ____

Substance (Circle)

Do you smoke? No Yes Former Smoker Packs per day? _____Years? _____
Smokeless Tobacco: Current User Former User Never Used
Consume Alcohol? No Yes
Drinks/Week: # Glasses of wine _____ # Cans of beer _____ #Shots of Liquor_____ #Standard drinks or equivalent _____
Drug Use? No Yes

Indicate if you had any of the gastrointestinal conditions listed: (Circle)

-Barrett's Esophagus	-Chronic constipation	-Gallbladder problems	-Colitis/Ulcerative
-Irritable Bowel Syndrome	-Yellow skin or jaundice	-Stomach or duodenal ulcer	-Celiac disease
-Anal fissure	-Colon polyps	-Diverticulosis	-Esophageal stricture or narrowing
-Intestinal infection	-Acid reflux/GERD	-Hemorrhoids	-Crohn's disease
-Diverticulitis	-Hepatitis C	-Autoimmune	-Alcohol abuse
-Gastrointestinal bleeding	-History helicobacter pylori		-Pancreatitis

Indicate if you had any of the non-gastrointestinal conditions listed: (Circle)

-High blood pressure	-Emphysema or COPD	- Congestive Heart Failure	-Hardening of the arteries
-Abnormal heartbeat/palpitations	-Treatment with blood thinner	-Heart disease/Heart attack	-Multiple Sclerosis
-HIV positive	-Exposure to HIV	-Thyroid disease	-Seizure disorder
-Bleeding disorder	-Arthritis	-High cholesterol	-Lupus
-Stroke	-Asthma	-Anemia	-Diabetes
-Fibromyalgia	-Blood clots	-Hypothyroid (low)	

Indicate if you had any of the types of Cancer listed: (Circle)

-Mouth/throat	-Esophagus	-Stomach	- Colon or rectum
-Blood (Leukemia)	-Prostate	- Lungs	- Breast
-Uterus	-Ovaries	- Skin	- Pancreas

Other: ____

What is your current relationship status: (Circle)

Divorced Married Separated Significant other Widowed Other

Do you live alone: (Circle)

Yes No

How many caffeinated beverages do you consume per day: (Circle)

None Occasional 1-2 3-5 More than 5

Have you traveled outside of the US in the past 6 months: (Circle)

Yes No

Have you engaged in high risk sexual behavior: (Circle)

Yes No

Have you ever had a blood transfusion: (Circle)

Yes No

Are you taking any fiber supplements: (Circle)

Yes No

Has your stool tested positive for blood: (Circle)

Yes No

Have you ever had x-rays, CT, or ultrasound of your abdomen or GI tract: (Circle)

Yes No

Please mark all GI tests that you have had: (Circle)

Colonoscopy Upper Endoscopy Flexible sigmoidoscopy ERCP (Endoscopy of Bile duct or pancreas)

Do you have an advance directive: (Circle)

Yes No

Do you have a defibrillator or pacemaker: (Circle)

Yes No

Have you previously had C. Diff: (Circle)

Yes No

Have you previously had MRSA: (Circle)

Yes No

MEDICATION LIST: (If you have more than 15 medications please attach a list of your medications)

NAME OF MEDICINE	DOSAGE	# PER DAY
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

Updated: 2/01/2018