COLON AND RECTAL ASSOCIATES, LTD.

1235 Old York Road, Suite G 20 * Abington, PA 19001 * Tel: 215-517-1250 * FAX: 215-517-0821
Joseph H. Nejman, M.D.
Steven G. Harper, M.D.
D. Mark Zebley, M.D.
Steven A. Fassler, M.D.
Soo Y. Kim, M.D.

Please bring the following items with you to your appointment:

1. 4 page information sheet **filled out completely** and **signed** making sure you list **all** of your medications both prescription and over-the-counter including dosages and directions. (We update this information quite frequently. Please complete these pages even if you have been seen by our doctors in the past.)

2. Photo ID (e.g.: Driver's License)

3. Insurance Cards (you will need to show them at every appointment)

4. Signed Patient Privacy Notice/Release of Medical and Billing Information

5. Signed Billing Policy Notice

6. Copayment (typically listed on your insurance card for specialist, **copay is due the day of your appointment**). We accept cash, check, Visa, MasterCard, Discover and American Express for your convenience.

If your insurance requires a referral, please be sure to request one at least 72 hours prior to your appointment date. Please use NPI#: 163-912-4720

We have two office locations. Please refer to the enclosed appointment card for the address where you have been scheduled, and report to that address.

Please arrive 15 minutes prior to your appointment time to allow time for check-in. Otherwise, your appointment may be delayed.

You must bring cash to exit the parking garage. Our office does not validate/stamp parking tickets and we cannot offer parking discounts.

Thank you for your cooperation.

Joseph H. Nejman, M.D.
Steven G. Harper, M.D.
D. Mark Zebley, M.D.

COLON AND RECTAL ASSOCIATES, LTD
COLON AND RECTAL SURGERY
PROCTOLOGY

Steven A. Fassler, M.D.
Soo Y. Kim, M.D.

PATIENT INFORMATION

*** Please PRINT in BLACK INK when completing * Please use your name as it appears on your insurance card ***

LAST NAME:________________ FIRST NAME:________________

MIDDLE INITIAL:_______ AGE:______ DATE OF BIRTH:__________ SSN:______-_____-______

SEX: MALE ☐ FEMALE ☐ GENDER:__________ E-MAIL ADDRESS:__________

MAILING ADDRESS:________________ APT/UNIT NO:__________

CITY:__________ STATE:______ ZIP:__________

PREFERRED PHONE#:________________ (HOME/CELL/WORK–PLEASE CIRCLE)

ALTERNATE PHONE#:________________ (HOME/CELL/WORK–PLEASE CIRCLE)

MARITAL STATUS:__________ SPOUSE'S NAME:__________

SPOUSE'S DATE OF BIRTH:__________ SPOUSE'S SSN:______-_____-______

EMERGENCY CONTACT:________________ RELATIONSHIP:__________

EMERGENCY CONTACT PHONE #:________________

RACE:__________ NO ANSWER ☐ ETHINICITY: HISPANIC OR LATINO ☐

LANGUAGE: ENGLISH ☐ OTHER:__________ NON-HISPANIC ☐ NO ANSWER ☐

OCCUPATION:________________ EMPLOYER:________________

REFERRING DOCTOR:________________ PHONE #:__________

FAMILY DOCTOR:________________ PHONE #:__________

CARDIOLOGIST:________________ PHONE #: __________

PHARMACY NAME:________________ PHARMACY PHONE #:__________

PHARMACY ADDRESS:________________________________

INSURANCE INFORMATION

PRIMARY INSURANCE CO. AND MEDICAL CLAIMS ADDRESS:________________

____

SUBSCRIBER'S NAME:________________ SUBSCRIBER'S DATE OF BIRTH:__________

ID #:________________ GROUP #:________________

SECONDARY INSURANCE CO. AND MEDICAL CLAIMS ADDRESS: ________________

____

SUBSCRIBER'S NAME:________________ SUBSCRIBER'S DATE OF BIRTH:__________

ID #:________________ GROUP #:________________

ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, and other private insurance, and any other health plan to COLON AND RECTAL ASSOCIATES, LTD. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

SIGNED:________________________________ **DATE:**________________

Please PRINT in BLACK INK when completing

COLON AND RECTAL ASSOCIATES, LTD. – PATIENT QUESTIONNAIRE – PAGE 2

PATIENT NAME:______________________________________DATE OF BIRTH:___________________________

TODAY'S DATE:__________________ PATIENT'S HEIGHT:__________________ WEIGHT:________________

State the reason why you are here, complaint, symptoms and duration: _______________________________________

Do you have, or have you in the past had, any of the conditions listed below:

Yes ☐ No ☐ Colon or Rectal Cancer (please circle which one). → If yes, age when diagnosed:_______________
Yes ☐ No ☐ Colon or Rectal Polyps (please circle which one). → If yes, age when diagnosed:_______________
Yes ☐ No ☐ Personal history of any other type of cancer. → If yes, age when diagnosed:___________________
What type?____
Yes ☐ No ☐ Radiation treatments for cancer What Type of Cancer?_______________________________________
Yes ☐ No ☐ Have you taken steroids (Prednisone, etc.) in the last 30 days?
Yes ☐ No ☐ Have you taken aspirin or non-steroidal anti-inflammatory drugs (Ibuprofen, Motrin, etc.) in the last seven days?
Yes ☐ No ☐ Thyroid problems
Yes ☐ No ☐ Diabetes (Type?________)
Yes ☐ No ☐ Arthritis
Yes ☐ No ☐ Recent fevers

Digestive System:

Yes ☐ No ☐ Inflammatory bowel disease (Crohn's disease or Ulcerative Colitis)
Yes ☐ No ☐ Diverticulitis
Yes ☐ No ☐ Diverticulosis
Yes ☐ No ☐ Rectal bleeding
(Describe the bleeding:______________________________)
Yes ☐ No ☐ Constipation, diarrhea, or a change in bowel habits
Yes ☐ No ☐ Fecal incontinence
Yes ☐ No ☐ Weight loss
Yes ☐ No ☐ Ulcers in the mouth
Yes ☐ No ☐ Ulcer of the stomach or duodenum (small intestine)
Yes ☐ No ☐ Gallbladder disease or gallstones
Yes ☐ No ☐ Liver disease or cirrhosis
Yes ☐ No ☐ Diseases of the pancreas
Yes ☐ No ☐ Gastritis (inflammation of the stomach)

Genitourinary System:

Yes ☐ No ☐ Kidney failure/dialysis
Yes ☐ No ☐ Urinary or prostate problems
Yes ☐ No ☐ Impotence
Yes ☐ No ☐ Do you have children?
Vaginal deliveries? Yes ☐ No ☐
Episiotomies? Yes ☐ No ☐
Cesarean Sections? Yes ☐ No ☐

Pulmonary System:

Yes ☐ No ☐ Asthma or emphysema
Yes ☐ No ☐ Pneumonia
Yes ☐ No ☐ Sleep apnea – If yes, do you require a CPAP? Yes ☐ No ☐

Cardiovascular System:

Yes ☐ No ☐ Defibrillator
Yes ☐ No ☐ Pacemaker
Yes ☐ No ☐ Chest pain or angina
Yes ☐ No ☐ Myocardial infarction (heart attack) When?_______________________
Yes ☐ No ☐ Palpitations or arrhythmias
Yes ☐ No ☐ Hypertension (high blood pressure)
Yes ☐ No ☐ Claudication (poor blood flow to the legs)
Yes ☐ No ☐ Blood clot in the legs
Yes ☐ No ☐ Blood clot in the lungs (pulmonary embolism)
Yes ☐ No ☐ Stroke
Yes ☐ No ☐ Previous organ transplant
Yes ☐ No ☐ Blood Disorder
Yes ☐ No ☐ HIV Positive
Yes ☐ No ☐ Previous blood transfusion
Yes ☐ No ☐ Easy bleeding or bruising
Yes ☐ No ☐ Anemia

Nervous System:

Yes ☐ No ☐ Neurologic illness
Yes ☐ No ☐ Psychiatric illness
Yes ☐ No ☐ Iritis (inflammation of the eyes)
Yes ☐ No ☐ Blindness

OTHER:____
____

Please PRINT in BLACK INK when completing

COLON AND RECTAL ASSOCIATES, LTD. – PATIENT QUESTIONNAIRE – PAGE 3

PATIENT NAME:____**DATE OF BIRTH:**____________________

TODAY'S DATE:____

SURGICAL HISTORY

Yes ☐ No ☐ Previous colon or rectal surgery (please list below)
Yes ☐ No ☐ Previous abdominal surgery (please list below)
Yes ☐ No ☐ Previous anal surgery (please list below)
Yes ☐ No ☐ Previous heart surgery (please list below)
Yes ☐ No ☐ Previous Knee/Hip/Joint Replacement (please indicate which joint and whether it was left or right side):____Date:_______________________
Yes ☐ No ☐ Have you ever had a Colonoscopy? (Date:________________Facility:______________________ Doctor:____________________)

LIST ALL PREVIOUS OPERATIONS (INCLUDE DATES IF POSSIBLE):______________________________

____

____

Yes ☐ No ☐ Have you ever had a Barium Enema? (Date:______________________________________)
Yes ☐ No ☐ Have you ever had a CT Scan (Date:____________Reason:_______________________)

FAMILY HISTORY

Please indicate if the family member is on the Paternal or Maternal side of your family

Yes ☐ No ☐ Do you have three or more relatives with Colon or Rectal cancer?

Please list anyone in your family with the following (please indicate N/A if no one in your family applies):

- Colon or Rectal cancer (please circle which one):
  - Who?____
- Colon or Rectal polyps
  - Who?____
- Any other type of cancer
  - Who?____
  - What type?____

Yes ☐ No ☐ Does anyone in your family have Inflammatory Bowel Disease (Crohn's disease or Ulcerative Colitis)
Yes ☐ No ☐ Do you have a first degree relative (parent, sibling, or child) who, before the age of 50, was diagnosed with cancer?

If yes, who?______________________What type of cancer?________________Age at diagnosis?________

SOCIAL HISTORY

Yes ☐ No ☐ Do you smoke cigarettes currently? Packs/day_______________
Yes ☐ No ☐ Have you ever smoked? When did you quit:______________
Yes ☐ No ☐ Do you drink alcohol? Drinks/week___________________
Yes ☐ No ☐ Have you ever been treated for substance abuse (alcohol, opioids, Etc.)?
What substance?____________________________
Yes ☐ No ☐ Have you ever used intravenous (IV) drugs?

Please PRINT in BLACK INK when completing

COLON AND RECTAL ASSOCIATES, LTD. – PATIENT QUESTIONNAIRE – PAGE 4

PATIENT NAME:____________________________________**DATE OF BIRTH:**______________________________

MEDICATIONS

☐ I take **NO** medications (prescription or over-the-counter) or any vitamins/supplements.

LIST ALL PERSCRIPTION MEDICATIONS:

NAME	DOSE	FREQUENCY

LIST ALL OVER-THE-COUNTER MEDICATIONS, VITAMINS, AND SUPPLEMENTS:

NAME	DOSE	FREQUENCY

ALLERGIES

Yes ☐ No ☐ Do you have any allergies?

LIST ALL ALLERGIES AND YOUR REACTIONS (Medications, Latex, Shellfish, Etc.):

______________________________________ ______________________________________

______________________________________ ______________________________________

______________________________________ ______________________________________

PATIENT SIGNATURE:____________________________________**TODAY'S DATE:**___________________________

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PATIENT PRIVACY NOTICE and

RELEASE OF MEDICAL/BILLING INFORMATION

BY SIGNING THIS, I ACKNOWLEDGE RECEIPT OF COLON AND RECTAL ASSOCIATES' PATIENT PRIVACY PRACTICES NOTICE (AS PER HIPAA).

You may find a readable copy of the Notice at the reception desk, request a copy of the Notice from the staff, or you may find it at http://www.colonandrectalassoc.com

◊ **If you wish to release your information to anyone, please indicate below. If you do not wish to release your information, please skip this section:**

I, ______________________________, authorize Colon and Rectal Associates and their staff to release information on file regarding my medical treatment, billing information and appointment information to the person(s) listed below:

Name:____Relationship:_____________________________

Name:____Relationship:_____________________________

Name:____Relationship:_____________________________

Name:____Relationship:_____________________________

◊ **If you do not wish to release your information, please complete the following section**:

I, _______________________________, do not authorize anyone to have access to my billing and medical information.

◊ **Please indicate if we may leave messages as described below**:

I give consent for the office to leave a message or text on my phone, answering machine, voicemail or with my spouse, parent or other household member. Yes_______ No_______

I give consent for the office to leave results of testing on my answering machine, by text, voicemail, or with a spouse, parent or other household member. Yes________ No_______

Patient's Printed Name:____**Date of Birth:**______________________________

_________________________________ _________________________

Patient Signature **Today's Date**

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BILLING POLICY

Thank you for choosing Colon and Rectal Associates, LTD. Our mission is to exceed our expectations by providing high quality care and achieving patient satisfaction. Your health and well-being is of the utmost importance to us. We have recently updated our billing policy. The cost of providing high quality care continues to rise and these changes are necessary to ensure that your needs are met. Effective June 1, 2017 our billing policy will be as follows:

1. All co-pays are due at time of service in order to be seen. Please contact your insurance company directly to confirm your co-pay amount for a specialist visit.

2. All referrals are due at time of service in order to be seen. We suggest you contact your PCP prior to your appointment with our office to confirm a referral was sent. Please request the confirmation number and date that the referral was issued.

3. All balances must be paid prior to services being rendered. All patient balances are due within 30 days of the statement date.

4. All patient balances and out of pocket fees including but not limited to, co-pays, co-insurance, and deductible are due no later than 48 hours prior to your scheduled procedure for service to be rendered. Please be advised you will be given an estimate for our physician's portion of your scheduled procedure and the amount is subject to change. You may also receive bills from the facility and the anesthesia physicians. After your claim is processed by your insurance carrier, if your remittance does not correspond with your remittance does not correspond with your insurance carrier's allowance, you will be billed for the difference or refunded for any overpayment.

We apologize for any inconvenience this may cause. However, no exceptions can be made as that would be a violation of our insurance contracts. As per the contractual agreement with our insurance carriers, we are unable to see patients without a co-pay or referral.

Please sign and date this document and return to the receptionist at your next appointment.

If you have any questions regarding this policy, please contact the office manager, Kelly Smith at 215-517-1250.

Patient's Printed Name:____Date of Birth:______________________

__________________________________ __________________________

Patient Signature Today's Date