PEDIATRIC GASTROENTEROLOGY AND NUTRITION
*682 EAST MAIN STREET, SUITE 2D * MIDDLETOWN, NY 10940*
TEL 845-341-0264 FAX 845-343-0962
www.gastropediatrics.com
160 N. Midland Road, 2nd Fl 510 Hamburg Tpke Suite 103
Nyack NY 10960 Wayne NJ 07470

NOTE TO PARENTS

- It is patient's parent's responsibility to have valid insurances, valid referral and co-pay money at the time of the appointment to avoid delays and uncomfortable situations in the waiting area.
- Failure to cancel the appointment 72 hours in advance is subject to a $50 fine.
- If you do not have insurance and willing to pay, we accept pre-paid consultation, cash and credit card payments only. Please call our office for more information about this.
- Office will do our best to obtain the pre-authorizations for procedures and medications if required by insurance, but we do not guarantee the positive outcome in all the cases since different insurance plans have their own rules that we would not be able to change. Involving benefit coordinator or calling the insurance and getting case manager in this case becomes the patient's family responsibility.
- If a referral is required by your insurance company, you are expected to have one at the time of your visit. If you do not have one please be prepared to pay for your visit in full by either cash or check, based on the services rendered. If you are unable to do so, please reschedule your appointment. To receive a referral you must contact your Primary Care Physician. If you are unsure whether or not you need a new referral for your next visit, please ask, we will be glad to look into it for you.
- It is our office policy that to receive a copy of your chart, we must have this request in writing. You may fill out a release form while at our office, email your request through our Patient Portal, or by fax. Please be aware that our office has 20 days from the requested date to have paper copies available to you. All paperwork is subject to a $0.75 per page charge and must be picked up at our office. We will fax the copies within three business days at no additional cost.
- All requests for letters for school and/or work should be submitted in the fax or portal form with child's last name, first name, DOB and special wording if required; the forms and letter will be done once we've obtained all necessary information. We prefer to communicate with family over e-mail via/portal our website www.gastropediatrics.com, thus eliminating playing phone tag with physician regarding treatments, abnormal laboratory results, forms and letters. Please make sure you have your PIN upon leaving the office after the first visit. Communication via regular e-mail is not HIPAA compliant and will not be accepted.
- If you are divorced parents, who do not communicate with each other verbally, please make sure both parents are present at the appointment, so the information is presented to both parents at the same time; or one is available by cell phone at the time of child's appointment. It is responsibility of the parents/patients to be compliant with follow up appointments, medical advice provided in person, by phone, mail or by portal. legal guardian or patient above 18 years must keep valid address and phone/ e-mail on file all the time. It is our unbendable rule.
- Any verbal or physical expression of aggression towards office staff or Doctors is the cause for immediate discharge from the practice.
- Having unpaid bills or being non compliant for any reason including but not limited to (cultural, religious, social, language, financial, etc) will subject patient to discharge from the practice without right for litigation and/or report to child welfare agency. If discharge should happen, the patient's records will be faxed to his/her Primary Care Physician/Pediatrician.
- Patient and legal guardian should always be present at the time of patient's appointment.
- I received all pertinent information and PIN for the Patient Portal.

Print Parent name Parent's Signature Date

ERENA TRESKOVA, M.D.
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To : Parents of

Athena# :

Date :

[ ]--- I agree

I am allowing the office of Dr Erena Treskova to collect co-payments and balances from my credit card. My insurance EOB (explanation of benefits) determines my outstanding balance and it is my responsibility to call my insurance regarding any questions about my balance. I am aware that office will contact me and leave message before charging my credit card.

Monthly payment : _____ collected on the 10th of the month 20% of outstanding balance

Full Name on Credit Card :

Email :

Credit Card# :

CVV (3 digits at the back of credit card) :

Expiration date :

Zip code :

Type : Visa Mastercard Discover

[ ]- I Dis-agree and I am paying in full my outstanding balance by cash, check or credit card at the time of appointment

Parents Signature: Parents Name :

Not paying the outstanding balance or failure to pay the monthly payment, will result for discharge from our practice.

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Patient Name:_____ Sex: M [ ] F [ ]

Date of Birth:_____/_____/_____ Age:_____ SS#:_____-_____-_____
Home Phone:( )_____ E-Mail:._____
Address:_____
City:_____ State:_____ Zip:_____

PCP/Pediatrician:_____ Phone:_____
Address:_____ Fax:_____
City:_____ State:_____ Zip:_____

Pharmacy:_____ Phone:_____

Allergies:_____

NAME OF LABORATORY FACILITY _____(City and State)

NAME OF IMAGING FACILITY _____ (City and State)

Mothers Name:_____
Employer:_____
Address:_____
City:_____ St:____ _Zip_____
Phone:( )_____
SS#:_____
Date of Birth:_____/_____/_____

Fathers Name:_____
Employer:_____
Address:_____
City:_____ St:____ _Zip_____
Phone:( )_____
SS#:_____
Date of Birth:_____/_____/_____

Insurance Information

Primary Insurance:_____Policy Holder:_____
Policy #:_____ Group #:_____
Do you need a Referral? Y [ ] N [ ] If yes, do you have it with you? Y [ ] N [ ]

Secondary Insurance:_____Policy Holder:_____
Policy #:_____ Group #:_____
Do you need a Referral? Y [ ] N [ ] If yes, do you have it with you? Y [ ] N [ ]

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage and assign directly to Dr. Treskova all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

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PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patient's consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operation.

As our patient, we want you to know that we respect the privacy of your personal medical information and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest. We also want you to know that we support your full access to your medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent. You may refuse to consent to the use or discloser of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your (PHI). You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name:_____

Signature:_____

Date:_____

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CONTACT INFORMATION

May we leave a message regarding your appointment....

On your answering machine __ Yes __ No

On your office voice mail __ Yes __ No

With another person __ Yes __ No

May we leave a message concerning your test results....

On your answering machine __ Yes __ No

On your office voice mail __ Yes __ No

With another person __ Yes __ No

Please list the persons authorized to receive the above information:

_____

_____

_____

Patient's Name:_____
PLEASE PRINT

Signature:_____ Date:_____

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HIPAA for MEDICATION HISTORY

Patients Name:_____

PLEASE PRINT

DOB:_____

I am allowing Dr. Erena Treskova to know the Medication History of my child.

DEMOGRAPHICS per INSURANCE REQUIREMENTS

Language: English ☐ Spanish ☐ Russian ☐ Chinese ☐ Other:_____ Decline ☐

Race: White ☐ African American ☐ European ☐ Other:_____ Decline ☐

Ethnicity: Not Hispanic/Latino ☐ Hispanic/Latino ☐ Other:_____ Decline ☐

Signature:_____

Today's Date:_____

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PLEASE TELL US HOW YOU HEARD ABOUT US?

_____ Internet:

_____ Search Engine (please specify) _____

_____ Hudson Valley Parent Website

_____ Bergen.com/family Website

_____ Insurance

_____ Pediatrician

_____ School Nurse

_____ School

_____ Friends

_____ Family

_____ Newspaper/Magazine:

_____ Newspaper (please specify)_____

_____ Hudson Valley Parent Magazine

_____ Radio

_____ Television

_____ Other (please specify) _____

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Patient's Name:_____ DOB:_____

Chief Complaints (Encounter Reason)
Please Check What Is Applicable To Patient

Abdominal pain
Anal pain
Blood in stool
Burning sensation in chest
Celiac
Cholelythiasis
Colic
Cough
Crohn's disease
Diarrhea
Dysphagia (pain with swallow)
Fatigue
Feeding difficulty
Fever
Hard bowel movements
Hematemesis (vomiting blood)
Hirschsprung's
Irregular bowel movements
Jaundice (yellow skin)
Liver problem
Mucus in stool
Nausea
Obesity
Problems gaining weight
Rectal bleeding
Regurgitation
Soiling of underwear
Ulcerative colitis
Vomiting
Weight loss

Failure to thrive (difficulty with weight and/or height gain)

Other:_____

_____

Please List All Medications

Please List All Allergies

Medication Name:

Seasonal:

Food (Please Specify):

Other:

Surgical
(Please Check What is Applicable to Patient)

Adenoidectomy _____
Anoplasty _____
Appendectomy _____
Cardiac _____
Circumcision _____
Cranial _____
Ganglion Cyst _____

Gastronomy Tube Replacement_____
Hernia _____

Myringotomy _____
Nissen Fundoplication _____
Orchopexy _____
Orthopedic _____
Renulectomy _____
Soft Tissue _____
Stitches _____
Tonsillectomy _____
Tracheotomy _____

Other _____

Patient's and Family Present and Past History
(Please specify type of illness i.e. GERD,IBS, Crohns)

	Mother	Father	Siblings	Grandparents
GI/Stomach				
Liver				
Instestines				

Note: _____

Epidermiology and Social History
(Please Answer The Following Questions)

Are immunizations up to date? _____

Alcohol Intake? _____

Iliicit Drugs? _____

Smoking? How much? _____

Advance Directive? _____

Sexually Active? _____

Parent's Signature: _____ Relationship to Patient: _____