How did you hear of us?
(Please check box)

- ☐ **Internet Search**
- ☐ **Friend/Family**
- ☐ **Dr. _____**
- ☐ **Insurance Company**

Office and Insurance Policies

We participate with numerous insurance plans. Please remember:

1) A referral from your primary physician with you if you need one.
2) A charge of $20 will be added to all returned checks.
3) Please try to provide 48-72 hours' notice for prescription refills.
4) If a Radiology test is ordered [i.e. CT scan, sonogram], we will obtain that authorization for you, most often within 48 hours.

Sunil Gupta, MD

Michael Kushner, MD

Can your results be given to your spouse, parent, or family member? _____Yes _____ No

If yes, name:_____

Can your appointment confirmation be left on your answering machine? _____ Yes _____ No
Can normal test results be left on your answering machine? _____ Yes _____ No
Can your test results be faxed to another physician's office? _____ Yes _____ No

Name of Pharmacy_____

Your Email Address:_____ (for access to patient portal)***

For State Regulatory Measures please answer the following questions:

Primary Language Spoken:_____ Race:_____ Ethnicity:_____

_____ _____
Patient's Signature Date

04/15

WESTCHESTER PUTNAM GASTROENTEROLOGY, PC

Name:_____ Date of Birth:_____ Sex (M/F):_____

Address:_____
Street City State Zip Code

Phone: (Home)_(___)_____ (Work)_(___)_____ Ext _____

Employer:_____ (Cell Phone)_(___)_____

Social Security No.:_____ Primary Care MD:_____

Name of Spouse:_____ Social Security No.:_____

Emergency Contact:_____ Phone:(___)_____

Allergies:_____

INSURANCE INFORMATION

Primary Insurance Carrier:_____

Name of Policy Holder:_____ Date of Birth of Policy Holder:_____

SS# of Policy Holder _____ ID #:_____ Group #:_____

Address of Insurance Company:_____

Secondary Insurance Carrier:_____

Name of Policy Holder:_____ Date of Birth of Policy Holder: _____

SS# of Policy Holder _____ ID #:_____ Group #:_____

Address of Insurance Company:_____

MEDICARE / MEDICAID

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr._____ for services furnished to me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing administration and its agents any information needed to determine these benefits or the benefits payable for related services.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical/medical benefits to Dr._____ for services rendered by him/her in person or under his/her supervision. I understand that I am financially responsible for any balance not covered by my insurance.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Dr._____ to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefits.

_____ _____

Patient's Signature Physician's Signature

WESTCHESTER PUTNAM GASTROENTEROLOGY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____ _____

Print Your Name Date

_____

Signature

FOR OFFICE USE ONLY

WE HAVE MADE EVERY EFFORT TO OBTAIN A WRITTEN ACKNOWLEDGEMENT OF RECEIPT OF OUR NOTICE OF PRIVACY FROM THIS PATIENT BUT IT COULD NOT BE OBTAINED BECAUSE:

_____ The patient refused to sign.

_____ Due to an emergency situation it was not possible to obtain an acknowledgement.

_____ We weren't able to communicate with the patient.

_____ Other (please provide specific details).

_____

_____

_____

_____

_____ _____

Employee Signature Date

Putnam Gastroenterology
T. 845.278.5223 WWW.PUTNAMGASTRO.COM
667 Stoneleigh Avenue, Carmel New York 10512

GASTROENTEROLOGY PROCEDURE SCHEDULING NOTICE

There have been many changes in the insurance world and there are hundreds of different insurance plans. It is impossible for us to know your individual benefits. We strongly suggest that all patients having an upcoming procedure contact their insurance company regarding their benefits and financial responsibility. Please keep in mind when contacting your insurance company that our doctors perform their procedures in an Ambulatory Surgery Center, not in an office setting.

Insurance companies have designated colonoscopies into two categories, screening and diagnostic.

Screening: Patients who are age 50 and over with no medical GI complaints, or patients who are under age 50 with an immediate family history of colonic polyps or colon cancer.

Diagnostic: Any GI medical complaint i.e.: rectal bleeding, change in bowel habits (diarrhea and or constipation) etc. With some insurance plans, personal history of polyps is considered diagnostic.

You may have been referred to us by your PCP for a screening colonoscopy or you may have received a reminder from us for your follow up colonoscopy. However, once any GI complaints are stated and documented by our provider this is no longer a screening colonoscopy, but is considered a diagnostic colonoscopy. Please do not ask us to change any codes to assist in insurance coverage, this is considered insurance fraud.

Patient Signature:_____ Date:_____