Westchester Putnam Gastroenterology, P.C.

Michael Kushner, MD **Sunil Gupta, MD** **Lizabeth Fiedler, MD**

The Barns Office Center
667 Stoneleigh Ave, Suite A201
Carmel, NY 10512
(845) 278 5223
(845) 278 4579

Office and Insurance Policies

1) In an appointment for a procedure is not cancelled at least 24 hours in advance, or if you do not show for your procedure, you will be charged a $200.00 cancellation fee. **This fee is not covered by insurance.**
2) Your co pay is dup upon check in on the day of your visit.
3) You will be notified by your insurance company on their explanation of benefits what portion of the charges they will cover and what portion you will be responsible for paying. **Our office will send you a statement for these balances, which should be settled within 60 days**. Please contact our office to arrange for payment plans or other ways to settle your account fairly.
4) **Accounts not paid within 60 days of invoice are subject to 1.5% monthly finance charge**.
5) We participate with most insurance plans, please contact your insurer for questions regarding network coverage.

Please initial in the space provided to confirm understanding of the above: _____

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 and address of Pharmacy_____

For State Regulatory Measures please answer the following questions:

Primary Language Spoken: _____ Race: _____ Ethnicity: _____

_____ _____
Patient's Signature Date

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 Date

Westchester Putnam Gastroenterology

667 Stoneleigh Avenue
Carmel, Ny 10512
P: (845) 278-5223 F: (845) 278-4579

Michael Kushner, MD
Sunil Gupta, MD
Lizabeth Fiedler, MD

Dear Patient,

In accordance to HIPAA regulations, we are taking your privacy very seriously. To help us protect your confidential information, please list the name and relationship of all persons that you would allow us to release and communicate your medical information to. This authorization will remain in effect until otherwise notified in writing.

Patient Name: _____

DOB: _____

Name of person(s) we may release your information to:

1. _____
Name Relationship Telephone #

2. _____
Name Relationship Telephone #

3. _____
Name Relationship Telephone #

Patient Signature: _____

Date: _____

Westchester Putnam Gastroenterology, P.C.

Michael Kushner, MD Sunil Gupta, MD Lizabeth Fiedler, MD

The Barns Office Center
667 Stoneleigh Ave, Suite A201
Carmel, NY 10512
(845) 278 5223
(845) 278 4579

Consent to Obtain External Pharmacy History

Why are we asking for this?

An accurate prescription history reduces medication errors and enhances your safety.

When you authorize Westchester Putnam Gastroenterology to access your external prescription history, you provide our staff with information about the medications you are already taking. This information will help Westchester Putnam Gastroenterology to minimize adverse drug events.

Drug interactions are examples of an adverse drug event. When you sign this consent, you are agreeing that Westchester Putnam Gastroenterology may request and use your prescription medication history from other healthcare providers and/or third-party pharmacy benefit payers for treatment purposes.

The Consent Statement

I understand that the prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be accessed by my provider and Westchester Putnam Gastroenterology. This may include prescriptions dating back several years.

My signature certifies, that I read and understood the scope of my consent and that I authorize the access.

Print Name _____ Date of Birth _____

Patient or Guardian Signature _____ Date _____

Westchester Putnam Gastroenterology, PC

667 Stoneleigh Avenue
Carmel, New York 10512
845-278-5223
WWW.PUTNAMGASTRO.COM

Michael Kushner, MD Sunil Gupta, MD Lizabeth Fiedler, MD

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.

1. **What's the difference between a screening and a diagnostic colonoscopy?**

   - A screening test is a test provided to a patient in the absence of signs or symptoms. A screening colonoscopy is a service performed on an asymptomatic person for the purpose of testing for the presence of colorectal cancer or colorectal polyps. Whether a polyp or cancer is ultimately found does not change the screening intent of that procedure. As part of the Affordable Care Act (ACA), Medicare and most third-party payors are required to cover services given an A or B rating by the U.S. Preventive Services Task Force (USPSTF) without a co-pay or deductible.
   - Diagnostic colonoscopy is a test performed as a result of an abnormal finding, sign or symptom (such as abdominal pain, bleeding, diarrhea, etc.). Medicare and most payors do not waive the co-pay and deductible when the intent of the visit is to perform a diagnostic colonoscopy.

IF A PATIENT PRESENTS FOR A SCREENING EXAM, THERE CAN NOT BE ANY "SYMPTOMS" ASSOCIATED WITH YOUR INDICATIONS

FOR EXAMPLE YOU CAN'T INDICATE: SCREENING EXAM, EPISODIC ABDOMINAL PAIN, OR OCCASIONAL BRB PER RECTUM

A PATIENT MUST BE ASYMPTOMATIC FOR A SCREENING, OTHERWISE WE CAN'T CODE IT AS SCREENING, AND THE INSURANCE COMPANIES WILL APPROACH IT AS DIAGNOSTIC, CHANGING PATIENT RESPONSIBILITY.

ALSO VERY IMPORTANT, PLEASE DO NOT DOCUMENT "BM REGULAR" THEN CODE BILLING AS CHANGE IN BOWEL HABITS.