WESTSIDE GASTROENTEROLOGY

_____Barry Jaffin MD _____ Anthony Weiss MD

Today's Date: _____

PATIENT INFORMATION:

Last Name: _____ First Name: _____ Middle Initial: _____ DOB: _____

Street Address: _____ Apt. #: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____ e-mail: _____

MAY WE LEAVE MESSAGES ON YOUR ANSWER MACHINE? YES _____ NO _____

MAY WE CALL YOU AT WORK? YES _____ NO _____

Marital Status: Single____ Married _____ Divorce _____ Widow _____ Other _____ Sex: Male ____ Female ____

Social Security: _____ Ocupation: _____

Name of Legally Responsible Representative: _____ Relationship to Patient: _____

IN CASE OF EMERGENCY CONTACT:

Last Name: _____ First Name: _____ Phone No: _____

Street Address: _____ Apt. # _____ City: _____ State: _____ Zip Code: _____

Relationship to Patient: _____

REFERRING PHYSICIAN INFORMATION:

Physician Name _____ Telephone No.: _____

Street Address: _____ Apt. # _____ City: _____ State: _____ Zip Code: _____

Is he / she your Primary Care Giver (PCP) Yes _____ No _____ (If no, please provide yourPrimary Physician information

PRIMARY PHYSICIAN INFORMATION:

Physician Name _____ Telephone No.: _____

Street Address: _____ Apt. # _____ City: _____ State: _____ Zip Code: _____

BILLING RESPONSABILITY: (IF DIFFERENT FROM PATIENT)

Last Name: _____ First Name: _____ Middle Initial: _____ DOB: _____

Social Security: _____ Relationship to patient: _____

INSURANCE INFORMATION:

Primary Insurance Name: _____ Insurance ID number: _____

Seconodary Insurance Name: _____ Insurance ID number: _____

YOU MUST SHOW YOUR INSURANCE CARDS AND PICTURE ID WHEN REGISTERING

PLEASE YOU MUST SIGN AT THE X's:

"I verify the accuracy of the above information and I authorize the release of information acquired in the course of my examination or treatment"

Patient Authorized Signature: _____ Date Signed: _____

"I authorize direct payment to the Physician or supplier for services provided"

Patient Authorized Signature: _____ Date Signed: _____

OFFICE USE ONLY

Patient's ID: _____ Receptionist Name: _____

MEDICATION FORM

Barry Jaffin, MD **Anthony Weiss, MD**

Date Form Started: _____

Name:	**Birth Date:**
Phone Number:	**Allergies:**

LIST ALL MEDICINES YOU ARE CURRENTLY TAKING: 1) Prescription and over-the-counter medications (examples: aspirin, antacids) herbals (examples: ginseng, gingko), and vitamins. Include medications taken as needed (example: nitroglycerin). Please also include if you received any injections recently, i.e. steroids. (**This form will be updated by you at every office visit**).

DATE PRE-SCIBED	NAME OF MEDICATION / DOSE	DIRECTIONS: (How many times a day do you take this and when.)	Medication held due to procedure		DATE STOPPED	Notes: Reason for taking / Doctor Name
			Yes	No		
			Yes	No		
			Yes	No		
			Yes	No		
			Yes	No		
			Yes	No		
			Yes	No		
			Yes	No		
			Yes	No		
			Yes	No		

PLEASE NOTE: THIS ORGANIZATION AND ITS PROVIDERS ARE NOT RESPONSIBLE FOR MEDICATIONS ORDERED BY OTHER ORGANIZATIONS OR PROVIDERS. The above is a list or your medications provided to us by yourself or responsible adult.

Patient Signature if applicable_____Date_____

Responsible Adult Signature_____Date_____

PHARMACY INFORMATION

Patient Name:		
Pharmacy Name:		
Pharmacy Street Address:	City, State:	Zip Code:
Pharmacy Phone No.:	Pharmacy Fax No:	
Patient Signature:		

BARRY W. JAFFIN, M.D.
ANTHONY WEISS, M.D.

☐ NEW ☐ CONSULT
NAME _____ DOB _____ DATE _____

HISTORY - COMPLETED BY PATIENT, STAFF OR PROVIDER

1. Reason for your visit today_____

_____

2. Please indicate if you are having any current problems signs or symptoms in any of the following areas
✓

☐ General wellness
☐ Eyes
☐ Skin
☐ Ears, Nose, Throat
☐ Stomach/Digestion
☐ Lungs/Breathing
☐ Heart/Circulation
Muscles/Joints/Bones
Extended. 10+complet
☐ Neurological
☐ Allergies
☐ Reproductive/Urinary
☐ Thyroid/Endocrine
☐ Psychiatric
☐ Blood/Lymph
☐ Other

3. Please list the medications you are taking. (SEE ATTACHED FORM FOR MEDICATIONS)

4. Please list the types and dates of any operations.

5. Are you allergic to any medicines or foods? _____

6. What is your Social History?
Marital Status: Single ☐, Divorced ☐, Married ☐, Widow/Widower ☐, who lives with you? _____
Current Occupation _____
Do you smoke? _____ How many packs a day? _____For how many years? _____
Do you drink alcohol? _____ How many drinks per day? _____Per week? _____Per month? _____

7. **Family Illnesses;** **Which relatives?**

History of high blood pressure? ☐ Yes ☐ No _____

History of diabetes? ☐ Yes ☐ No _____

History of Heart Disease? ☐ Yes ☐ No _____

History of Strokes? ☐ Yes ☐ No _____

History of cancer? ☐ Yes ☐ No _____

BARRY W. JAFFIN, M.D.
ANTHONY WEISS, M.D.

You and Your Family's Cancer History:

Please check if you or whom in your family has/had cancer.

Y N	Cancer	You (Age of Diagnosis)	Parent / Siblings/Children	AGE of Diagnosis	Relatives on your Mother's side	AGE of Diagnosis	Relatives on your Father's side	AGE of Diagnosis
Y N	**Breast Cancer**							
Y N	**Ovarian Cancer**							
Y N	**Uterine Cancer** (Endometrial)							
Y N	**Colon / Rectal Cancer**							
Y N	10 or more **Lifetime Colon Polyps**							
Y N	**Other Cancer**							

NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT

BARRY W. JAFFIN, M.D.
ANTHONY WEISS, M.D.
620 COLUMBUS AVENUE
NEW YORK, NY 10024
Phone (212) 721-2600
Fax (212) 721-6230

Patient Name: _____ **Date of Birth:** _____

I understand that, under the Health Insurance Portability Accountability of 1996, I have certain rights to privacy in regards to my protected health information (PHI). I have received, read and understood The Notice of Privacy Practice.

I have reviewed and understand, and a copy of the following information has been made available to me: Information regarding the ownership of the practice; the expertise of the associated physicians; the Patient Rights and Responsibilities; the Patient Grievance Process; DNR policy' Notice of Privacy Practice. (Westside Gastroenterology cannot honor Do Not Resuscitate (DNR) or Living Wills.

The Practice reserves the right to change the terms of its Notice of Privacy Practice. I understand the Practice will provide current Notice of Privacy Practice on request.

Signature: _____

Relationship: _____

Date: _____

_____

_____

I _____ was unable to obtain the patients signature.
Name of person obtaining signature

Date: _____ Name of Patient: _____

Reason: _____

_____

_____

INDIVIDUAL PATIENT DISCLOSURE AUTHORIZATON FORM

BARRY W. JAFFIN, M.D.
ANTHONY WEISS, M.D.
620 COLUMBUS AVENUE
NEW YORK, NY 10024
Phone (212) 721-2600
Fax (212) 721-6230

Patient Name: _____ Date of Birth: _____

I hereby give my authorization to disclose my protected health information only in the specific manner, for the named reason, and to the specific individuals below.

Specific description of information to use on disclose:

_____

_____

_____

Reason (event) for requested disclosure:

_____

_____

Person or entity requesting information: _____

Recipient of the information: _____

I understand this authorization provides that:

- I have the right to access my protected health information to be used or disclosed
- I may revoke this authorization at any time by contacting your Privacy Officer in writing at the address above.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPPA privacy rules.
- This practice will not condition treatment on my providing authorization for the requested use on disclosure.
- I will receive a copy of this completed and signed authorization form.

Signature: _____ Date: _____

Relationship of patient (if signed by a personal representative of patient) _____

Telephone: 212 721-2600
FX: 212 721-6230

WESTSIDE GASTROENTEROLOGY
Barry Jaffin M.D., Anthony Weiss M.D.
620 Columbus Avenue
New York, NY 10024

Financial Agreement

We are committed to providing you with the best possible care and are please to discuss our professional fees with you at any time. Your clear understanding of our Financial Agreement is important to our professional relationship.

PATIENTS MUST FILL OUT PATIENT INFORMATION FORMS PRIOR TO SEEING THE DOCTOR. WE WILL REQUEST TO PHOTOCOPY YOUR INSURANCE CARD(S) FOR YOUR FILE. WE ALSO REQUEST A PHOTO ID FOR YOUR FILE.

REFERRALS- If your plan requires a referral form your primary care physician, it is YOUR responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If you do not have your referral, YOU WILL BE REQUESTED TO SIGN A FINANCIAL WAIVER and will be personally responsible for that day's services.

CO-PAYMENTS- By law we MUST collect your carrier designated co-pay. This payment is expected at the time of service. Please be prepared to pay the co-pay at each visit. **There will be a charge of $20 for unpaid copayment at time of service.**
As per your Insurance Company, you are responsible for your Deductibles, Co-Insurances and or Co-payment balances.

OUT OF NETWORK PLANS- If we do not "Participate" with your plan payment will be expected at the time of service, unless prior arrangements have been made with our financial staff including co-insurance, deductible and non-covered amount. We will send a courtesy bill to the carrier on your behalf.

If your insurance is inactive or terminated at the time of service and you fail to inform us, you are responsible for the full amount.

Private Insurance Authorization for Assignment of Benefits/Information Release: I undersigned, authorize payment of medical benefits to Westside Gastroenterology (Barry Jaffin MD, Anthony Weiss MD) for any services furnished. I understand that I am financially responsible for any amount not covered by my contract. I also authorize any holder of medical information about me to release to my insurance company (or their agent) information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

SELF-PAY PATIENTS- Payment is expected at the time of service unless other financial arrangements have been made prior to your visit.

MEDICARE- We will submit claims to Medicare. The patient will be responsible for the deductible and the 20% co-insurance, which can be billed to a secondary insurance if you have one. (*Dr. Barry Jaffin and Dr. Anthony Weiss does not participate with Medicaid*)

Medicare Lifetime Signature on File: I request that payment of authorized Medicare benefits be made on my behalf to the Westside Gastroenterology (Barry Jaffin MD, Anthony Weiss MD) for any services furnished to me. I authorize any holder of medical information about me to release to CMS (and its agents) any information to determine these benefits payable for related services. This information will be used for the purpose of evaluating and administering claims on benefits.

You are responsible for the timely payment of your account. Our financial staff will work closely with you and your carrier to avoid sending any account to an outside agency to collect payment. We reserve the right to send delinquent accounts to an outside collection agency.
We accept CASH, CHECKS, MASTERCARD, VISA or AMERICAN EXPRESS CARDS.

If your insurance is inactive or terminated at the time of service and you fail to inform us, you are responsible for the full amount.
Thank you for taking the time to review our policies. Please feel free to ask any questions of share with us special concerns.

Patient Signature:	Date:
Patient Name:	