PATIENT INFORMATION

NAME____ AGE________ SEX ________

SOCIAL SECURITY NO.______________________________ DATE OF BIRTH ____________________

HOME ADDRESS____

CITY STATE ZIP ____________________________ REFERRED BY ______________________________

SINGLE [ ] MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

HOME PHONE ______________________________ CELL PHONE ______________________________

WORK PHONE ______________________________ E-MAIL______ ______________________________

OCCUPATION ______________________________ EMPLOYER ________________________________

WORK ADDRESS ____

CITY STATE ZIP ____

PRIMARY INSURANCE ___________________________ POLICY HOLDER ______________________

IDENTIFICATION NO. __________________________________ GROUP NO. ______________________

ADDRESS ____

CITY STATE ZIP __________________________________ PHONE NO. ___________________________

SECONDARY INSURANCE ________________________ POLICY HOLDER ______________________

IDENTIFICATION NO. _________________________________ GROUP NO. _______________________

ADDRESS ____

CITY STATE ZIP____________________________________ PHONE NO. __________________________

DRIVERS LIC. NO.____ STATE _____________

CREDIT CARD ___________________ NUMBER _______________________________ EXPIRES ______

PERSON TO CONTACT IN EMERGENCY ____

HOME PHONE _______________________________ WORK PHONE ______________________________

CELL PHONE ________________________________ RELATION TO PATIENT ______________________

X ____ DATE ____________________

SIGNATURE

NEW PATIENT MEDICAL QUESTIONNAIRE, Page 1

Name ____________________________________ Birth Date____________ Sex ____ S M W D Occupation ____________________

Chief complaint (Why are you here?)____

____

Current prescription medications ____

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OTC Medications, Vitamins, Supplements____

Allergies to medications___________________________________ Any other allergies?________________________________

Tobacco Use (how much, how long)_________________________ Alcohol (how much in average week) __________________________

Current Weight _______________________ Weight one year ago _____________________ Maximum weight_____________________

Current medical problems/diagnoses ____

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____

Previous medical history ____

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Hospitalizations, Surgery ____

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Family history: Cancer [ ] Heart Disease [ ] Diabetes [ ] High Blood Pressure [ ] Colitis [ ] Emotional problems [ ] Early death [ ]

Details of Family History ____

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Have you ever had: Colonoscopy [ ] Rectal Bleeding [ ] Black tarry stools [ ] Vomiting blood [ ] Inflammatory Bowel Disease [ ]

Ulcerative colitis [ ] Crohn's Disease [ ] Hemorrhoids [ ] Diverticulitis [ ] Food allergies [ ] Malabsorption syndrome [ ]

Irritable bowel syndrome (IBS) [ ] Prolonged constipation [ ] Prolonged diarrhea [ ] Intestinal infections [ ] Parasites or worms [ ]

Other bowel disease [ ] Stomach trouble [ ] Ulcers [ ] Hiatus hernia [ ] Reflux/GERD [ ] Excessive gas [ ] Gallbladder disease [ ]

Liver disease [ ] Immunization for hepatitis A [ ] for hepatitis B [ ] Jaundice [ ] Pancreatitis [ ] Recent change in appetite [ ]

Sexually transmitted diseases [ ] **Explain any positives:** ____

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NEW PATIENT MEDICAL QUESTIONNAIRE, Page 2

Screening for preventable medical problems: Have you ever been screened for:

	Yes	No	N/A	When was the last time?
Colorectal cancer?	[ ]	[ ]		______________________
Breast cancer?	[ ]	[ ]	[ ]	______________________
Cervical cancer?	[ ]	[ ]	[ ]	______________________
Prostate cancer?	[ ]	[ ]	[ ]	______________________
Osteoporosis?	[ ]	[ ]	[ ]	______________________

Social History:

	Yes	No		Yes	No	N/A		Yes	No
Do you exercise adequately?	[ ]	[ ]	Do you sleep well?	[ ]	[ ]		Do you like your work?	[ ]	[ ]
Are you sexually active?	[ ]	[ ]	Is sex satisfactory?	[ ]	[ ]	[ ]	Treatment for alcoholism?	[ ]	[ ]
							Treatment for drug abuse?	[ ]	[ ]

Emotional History:

		Yes	No		Yes	No		Yes	No
Are you often:	Depressed?	[ ]	[ ]	Anxious?	[ ]	[ ]	Irritable?	[ ]	[ ]
	Jumpy or jittery?	[ ]	[ ]	Unable to concentrate?	[ ]	[ ]			

Explain any pertinent details: ____

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For Women Only:

Menstrual history: Age at onset ___________ Usual duration of periods ________________ Interval between periods ________________

Are your periods regular? Y / N Date of last period __________________ Are you usually: Heavy [ ] Medium [ ] Light [ ]

Before periods, do you have: tension? Y/N depression? Y/N mood swings? Y/N. During periods, do you have cramps? Y/N pain? Y/N

Pregnancies: How many? ___________ Children: __________ Caesarean sections? ____________ Premature births? ______________

Complications? ____

Are there any other issues you wish to discuss with the doctor today? ____

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NEW PATIENT AGREEMENT - Page 1

PATIENT NAME____
I certify by my signature below I have full and current coverage for medical and surgical care by:

____

Name of Insurance Plan

1. **Co-pays and deductibles -** I am aware that my insurance plan requires payment of all **co-pays** at the time of service. There will be an administrative service fee of $20, in addition to my co-pay, if I do not pay this at the time of service. I agree to pay all **deductibles** in full at the time of service, or immediately upon receipt of a bill for a deductible.

2. In the event my insurance plan denies reimbursement to Dr. Finkel because my insurance was **not in effect on the date of service**, I understand that I will be personally responsible for his full fee. I agree to full personal financial responsibility in the event of non-coverage or denial of reimbursement by my insurance plan for services rendered by Dr. Finkel.

3. In the event I am seeing Dr. Finkel **in consultation as a GI specialist,** if my plan requires referrals, I am responsible for providing a **written referral - or hard copy of an electronic referral** from my PCP, except in the event of an emergency. If I do not provide such a referral from my PCP, I understand that I will be personally responsible for Dr. Finkel's fee, and I guarantee such payment in full, or I will not be seen by Dr. Finkel until a referral is obtained.

4. I authorize Dr. Finkel to send any and all information to my insurance plan necessary to process his claims for services rendered to me, including copies of my medical records, if required, with the exception of HIV/AIDS-related information, which cannot be submitted to any third party without my specific written consent, as specified by NY State law. I also authorize Dr. Finkel to provide my plan with access to my medical records for purposes of documentation of services, quality assurance, utilization review, and/or for any other purpose for which my plan may require my records, subject to HIPAA confidentiality laws, and except as noted for HIV/AIDS-related records.

5. **Cancellation and "No-Show" Policy: 24 hours' notice of cancellation is required. Failure to keep an office appointment, or cancellation with less than 24 hours' notice, will result in a charge of $50.00 that is payable by you, personally. Failure to keep an appointment for an outpatient hospital procedure, or cancellation with less than 24 hours' notice, will result in a charge of $250.00.** Two consecutive no-shows, or a total of three no-shows, may be grounds for Dr. Finkel to discharge you as a patient, with written notification to you and your insurance plan. In such a situation, Dr. Finkel will remain your physician for no more than 30 days, or until you have found a new MD, whichever comes first.

6. **Checks returned for "insufficient funds"** or any other reason will be subject to a charge of **$50.00.**

7. **Pregnancy:** In the event you are, or become pregnant, your OB-GYN will be your primary physician for the duration of your pregnancy. All medical care, prescriptions, testing, and referrals will be the responsibility of your OB-GYN while you are pregnant. Under special circumstances, Dr. Finkel may act as a GI specialist during your pregnancy, but only with the approval and participation of your OB-GYN. If you are seeing an "out-of-network" OB-GYN, Dr. Finkel will not authorize "in-network" insurance coverage for any testing ordered by the out-of-network doctor.

NEW PATIENT AGREEMENT - Page 2

8.**Genetic Testing:** Dr. Finkel does not provide genetic counseling. In the event you want "in-network" coverage to pay for genetic testing, either you will need to see an in-network genetic specialist, or you will waive, by your signature below, any and all liability on the part of Dr.Finkel with respect to such testing, including but not limited to the failure to diagnose one or more genetic conditions. Dr. Finkel will not order any genetic testing unless you acknowledge, by your signature below, that you have already received, or will receive genetic counseling from an appropriate specialist in medical genetics, including counseling based on the results of any genetic testing ordered by Dr. Finkel at your request.

9. **Referrals:** If you are in a plan that requires a formal referral, please be advised we will not authorize "same-day referrals" if you go to a specialist without first seeing Dr. Finkel, unless there is a documented medical emergency confirmed by the specialist. In the event you see a specialist, or go for diagnostic testing without proper referral, you may have to cancel the appointment or pay for it yourself. "Retroactive referrals" are not permitted.

10. I understand that if I need repeated or ongoing authorizations or referrals from Dr. Finkel in order to continue visits to a participating specialist, Dr. Finkel may require periodic **written documentation from the specialist** indicating the need for ongoing care.

11.**Completion of forms** (other than insurance forms): There will be a charge of **$25.00** for completion of forms or letters for work, school, camp, jury duty, etc. There is no charge for completion or submission of insurance forms pursuant to medical services rendered in this office, or at the hospital by Dr. Finkel.

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12. AUTHORIZATION FOR RELEASE OF RECORDS AND MEDICARE BENEFITS:

I request that authorized Medicare benefits be made either to me, or on my behalf to Dr. Finkel, for any services rendered to me by him. I authorize any holder of medical information about me to release to the Health Care Finance Administration [HCFA] and its agents any information needed to determine these benefits, or the benefits payable for related services.

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NAME ____

SIGNATURE ____ **DATE** ________________