

COLON AND RECTAL ASSOCIATES, LTD.

1235 Old York Road, Suite G 20 * Abington, PA 19001 * Tel: 215-517-1250 * FAX: 215-517-0821

Joseph H. Nejman, M.D.

Steven G. Harper, M.D.

D. Mark Zebley, M.D.

Steven A. Fassler, M.D.

Soo Y. Kim, M.D.

Please bring the following items with you to your appointment:

1. 4 page information sheet **filled out completely** and **signed** making sure you list **all** of your medications both prescription and over-the-counter including dosages and directions. (We update this information quite frequently. Please complete these pages even if you have been seen by our doctors in the past.)
2. Photo ID (e.g.: Driver's License)
3. Insurance Cards (you will need to show them at every appointment)
4. COVID-19 CDC Vaccination Card
5. Signed Patient Privacy Notice/Release of Medical and Billing Information
6. Signed Billing Policy Notice
7. Copayment (typically listed on your insurance card for specialist, **copay is due the day of your appointment**). We accept cash, check, Visa, MasterCard, Discover and American Express for your convenience.

If your insurance requires a referral, please be sure to request one at least 72 hours prior to your appointment date. Please use NPI#: 163-912-4720

We have two office locations. Please refer to the enclosed appointment card for the address where you have been scheduled, and report to that address.

Please arrive 15 minutes prior to your appointment time to allow time for check-in. Otherwise, your appointment may be delayed.

You must bring cash to exit the parking garage. Our office does not validate/stamp parking tickets and we cannot offer parking discounts.

Thank you for your cooperation.

Joseph H. Nejman, M.D.
Steven G. Harper, M.D.
D. Mark Zebley, M.D.

COLON AND RECTAL ASSOCIATES, LTD
COLON AND RECTAL SURGERY
PROCTOLOGY

Steven A. Fassler, M.D.
Soo Y. Kim, M.D.

PATIENT INFORMATION

* Please PRINT in BLACK INK when completing * Please use your name as it appears on your insurance card *

LAST NAME: _____ FIRST NAME: _____

MIDDLE INITIAL: _____ AGE: _____ DATE OF BIRTH: _____ SSN: _____ - _____ - _____

SEX: MALE FEMALE GENDER: _____ E-MAIL ADDRESS: _____

MAILING ADDRESS: _____ APT/UNIT NO: _____

CITY: _____ STATE: _____ ZIP: _____

PREFERRED PHONE#: _____ (HOME/CELL/WORK-PLEASE CIRCLE)

ALTERNATE PHONE#: _____ (HOME/CELL/WORK-PLEASE CIRCLE)

MARITAL STATUS: _____ SPOUSE'S NAME: _____

SPOUSE'S DATE OF BIRTH: _____ SPOUSE'S SSN: _____ - _____ - _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____

EMERGENCY CONTACT PHONE #: _____

RACE: _____ NO ANSWER ETHNICITY: HISPANIC OR LATINO

LANGUAGE: ENGLISH OTHER: _____ NON-HISPANIC NO ANSWER

OCCUPATION: _____ EMPLOYER: _____

REFERRING DOCTOR: _____ PHONE #: _____

FAMILY DOCTOR: _____ PHONE #: _____

CARDIOLOGIST: _____ PHONE #: _____

PHARMACY NAME: _____ PHARMACY PHONE #: _____

PHARMACY ADDRESS: _____

INSURANCE INFORMATION

PRIMARY INSURANCE CO. AND MEDICAL CLAIMS ADDRESS: _____

SUBSCRIBER'S NAME: _____ SUBSCRIBER'S DATE OF BIRTH: _____

ID #: _____ GROUP #: _____

SECONDARY INSURANCE CO. AND MEDICAL CLAIMS ADDRESS: _____

SUBSCRIBER'S NAME: _____ SUBSCRIBER'S DATE OF BIRTH: _____

ID #: _____ GROUP #: _____

ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, and other private insurance, and any other health plan to COLON AND RECTAL ASSOCIATES, LTD. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

SIGNED: _____ DATE: _____

Please PRINT in BLACK INK when completing

COLON AND RECTAL ASSOCIATES, LTD. – PATIENT QUESTIONNAIRE – PAGE 2

PATIENT NAME: _____ **DATE OF BIRTH:** _____

TODAY'S DATE: _____ **PATIENT'S HEIGHT:** _____ **WEIGHT:** _____

State the reason why you are here, complaint, symptoms and duration: _____

Do you have, or have you in the past had, any of the conditions listed below:

Yes No Colon or Rectal Cancer (please circle which one). → If yes, age when diagnosed: _____

Yes No Colon or Rectal Polyps (please circle which one). → If yes, age when diagnosed: _____

Yes No Personal history of any other type of cancer. → If yes, age when diagnosed: _____
What type? _____

Yes No Radiation treatments for cancer What Type of Cancer? _____

Yes No Have you taken steroids (Prednisone, etc.) in the last 30 days?

Yes No Have you taken aspirin or non-steroidal anti-inflammatory drugs (Ibuprofen, Motrin, etc.) in the last seven days?

Yes No Thyroid problems

Yes No Diabetes (Type? _____)

Yes No Arthritis

Yes No Recent fevers

Pulmonary System:

Yes No Asthma or emphysema

Yes No Pneumonia

Yes No Sleep apnea – If yes, do you require a CPAP? Yes No

Digestive System:

Yes No Inflammatory bowel disease (Crohn's disease or Ulcerative Colitis)

Yes No Diverticulitis

Yes No Diverticulosis

Yes No Rectal bleeding

(Describe the bleeding: _____)

Yes No Constipation, diarrhea, or a change in bowel habits

Yes No Fecal incontinence

Yes No Weight loss

Yes No Ulcers in the mouth

Yes No Ulcer of the stomach or duodenum (small intestine)

Yes No Gallbladder disease or gallstones

Yes No Liver disease or cirrhosis

Yes No Diseases of the pancreas

Yes No Gastritis (inflammation of the stomach)

Cardiovascular System:

Yes No Defibrillator

Yes No Pacemaker

Yes No Chest pain or angina

Yes No Myocardial infarction (heart attack) When? _____

Yes No Palpitations or arrhythmias

Yes No Hypertension (high blood pressure)

Yes No Claudication (poor blood flow to the legs)

Yes No Blood clot in the legs

Yes No Blood clot in the lungs (pulmonary embolism)

Yes No Stroke

Yes No Previous organ transplant

Yes No Blood Disorder

Yes No HIV Positive

Yes No Previous blood transfusion

Yes No Easy bleeding or bruising

Yes No Anemia

Genitourinary System:

Yes No Kidney failure/dialysis

Yes No Urinary or prostate problems

Yes No Impotence

Yes No Do you have children?

Vaginal deliveries? Yes No

Episiotomies? Yes No

Cesarean Sections? Yes No

Nervous System:

Yes No Neurologic illness

Yes No Psychiatric illness

Yes No Iritis (inflammation of the eyes)

Yes No Blindness

OTHER: _____

Please PRINT in BLACK INK when completing

COLON AND RECTAL ASSOCIATES, LTD. – PATIENT QUESTIONNAIRE – PAGE 3

PATIENT NAME: _____ DATE OF BIRTH: _____

TODAY'S DATE: _____

SURGICAL HISTORY

- Yes No Previous colon or rectal surgery (please list below)
Yes No Previous abdominal surgery (please list below)
Yes No Previous anal surgery (please list below)
Yes No Previous heart surgery (please list below)
Yes No Previous Knee/Hip/Joint Replacement (please indicate which joint and whether it was left or right side): _____ Date: _____
Yes No Have you ever had a Colonoscopy? (Date: _____ Facility: _____ Doctor: _____)

LIST ALL PREVIOUS OPERATIONS (INCLUDE DATES IF POSSIBLE):

- Yes No Have you ever had a Barium Enema? (Date: _____)
Yes No Have you ever had a CT Scan (Date: _____ Reason: _____)

FAMILY HISTORY

Please indicate if the family member is on the Paternal or Maternal side of your family

- Yes No Do you have three or more relatives with Colon or Rectal cancer?

Please list anyone in your family with the following (please indicate N/A if no one in your family applies):

- ❖ Colon or Rectal cancer (please circle which one):
 - Who? _____
- ❖ Colon or Rectal polyps
 - Who? _____
- ❖ Any other type of cancer
 - Who? _____
 - What type? _____

- Yes No Does anyone in your family have Inflammatory Bowel Disease (Crohn's disease or Ulcerative Colitis)

- Yes No Do you have a first degree relative (parent, sibling, or child) who, before the age of 50, was diagnosed with cancer?

If yes, who? _____ What type of cancer? _____ Age at diagnosis? _____

SOCIAL HISTORY

- Yes No Do you smoke cigarettes currently? Packs/day _____
Yes No Have you ever smoked? When did you quit: _____
Yes No Do you drink alcohol? Drinks/week _____
Yes No Have you ever been treated for substance abuse (alcohol, opioids, Etc.)?
What substance? _____
Yes No Have you ever used intravenous (IV) drugs?

Please PRINT in BLACK INK when completing

COLON AND RECTAL ASSOCIATES, LTD. – PATIENT QUESTIONNAIRE – PAGE 4

PATIENT NAME: _____ DATE OF BIRTH: _____

MEDICATIONS

I take **NO** medications (prescription or over-the-counter) or any vitamins/supplements.

LIST ALL PERSCRIPTION

MEDICATIONS:

NAME DOSE FREQUENCY

LIST ALL OVER-THE-COUNTER

MEDICATIONS, VITAMINS, AND

SUPPLEMENTS:

NAME DOSE FREQUENCY

ALLERGIES

Yes No Do you have any allergies?

LIST ALL ALLERGIES AND YOUR REACTIONS (Medications, Latex, Shellfish, Etc.):

PATIENT SIGNATURE: _____ TODAY'S DATE: _____

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PATIENT PRIVACY NOTICE and

RELEASE OF MEDICAL/BILLING INFORMATION

BY SIGNING THIS, I ACKNOWLEDGE RECEIPT OF COLON AND RECTAL ASSOCIATES' PATIENT PRIVACY PRACTICES NOTICE (AS PER HIPAA).

You may find a readable copy of the Notice at the reception desk, request a copy of the Notice from the staff, or you may find it at <http://www.colonandrectalassoc.com>

- ◇ **If you wish to release your information to anyone, please indicate below. If you do not wish to release your information, please skip this section:**

I, _____, authorize Colon and Rectal Associates and their staff to release information on file regarding my medical treatment, billing information and appointment information to the person(s) listed below:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

- ◇ **If you do not wish to release your information, please complete the following section:**

I, _____, do not authorize anyone to have access to my billing and medical information.

- ◇ **Please indicate if we may leave messages as described below:**

I give consent for the office to leave a message or text on my phone, answering machine, voicemail or with my spouse, parent or other household member. Yes _____ No _____

I give consent for the office to leave results of testing on my answering machine, by text, voicemail, or with a spouse, parent or other household member. Yes _____ No _____

Patient's Printed Name: _____ Date of Birth: _____

Patient Signature

Today's Date

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BILLING POLICY

Thank you for choosing Colon and Rectal Associates, LTD. Our mission is to exceed our expectations by providing high quality care and achieving patient satisfaction. Your health and well-being is of the utmost importance to us. We have recently updated our billing policy. The cost of providing high quality care continues to rise and these changes are necessary to ensure that your needs are met. Effective June 1, 2017 our billing policy will be as follows:

1. All co-pays are due at time of service in order to be seen. Please contact your insurance company directly to confirm your co-pay amount for a specialist visit.
2. All referrals are due at time of service in order to be seen. We suggest you contact your PCP prior to your appointment with our office to confirm a referral was sent. Please request the confirmation number and date that the referral was issued.
3. All balances must be paid prior to services being rendered. All patient balances are due within 30 days of the statement date.
4. All patient balances and out of pocket fees including but not limited to, co-pays, co-insurance, and deductible are due no later than 48 hours prior to your scheduled procedure for service to be rendered. Please be advised you will be given an estimate for our physician's portion of your scheduled procedure and the amount is subject to change. You may also receive bills from the facility and the anesthesia physicians. After your claim is processed by your insurance carrier, if your remittance does not correspond with your remittance does not correspond with your insurance carrier's allowance, you will be billed for the difference or refunded for any overpayment.

We apologize for any inconvenience this may cause. However, no exceptions can be made as that would be a violation of our insurance contracts. As per the contractual agreement with our insurance carriers, we are unable to see patients without a co-pay or referral.

Please sign and date this document and return to the receptionist at your next appointment.

If you have any questions regarding this policy, please contact the office manager, Kelly Smith at 215-517-1250.

Patient's Printed Name: _____ Date of Birth: _____

Patient Signature

Today's Date