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.
David G. McKeown, M.D.

Please bring the following items with you to your appointment:
FORMS ARE TO BE COMPLETED, SIGNED and DATED. FORMS MAY NOT BE ALTERED IN ANY WAY

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. Signed Patient Privacy Notice/Release of Medical and Billing Information

5. Signed Billing Policy Notice

6. Copayment (typically listed on your insurance card for specialist, **copay is due the day of your appointment**). We accept (Cash, Debit Card, HAS Card, Money Order, Visa, MasterCard, Discover and American Express) for your convenience.

7. Credit Card to be put on file

8. Credit Card on File Authorization form

9. Patient Financial Responsibility Form

If your insurance requires a referral, please be sure to request one at least 72 hours prior to your appointment date. Please use NPI#: 1639124720

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 or Credit/Debit card to exit the parking garage. Our office does not validate/stamp parking tickets and we cannot offer parking discounts.

Thank you for your cooperation.

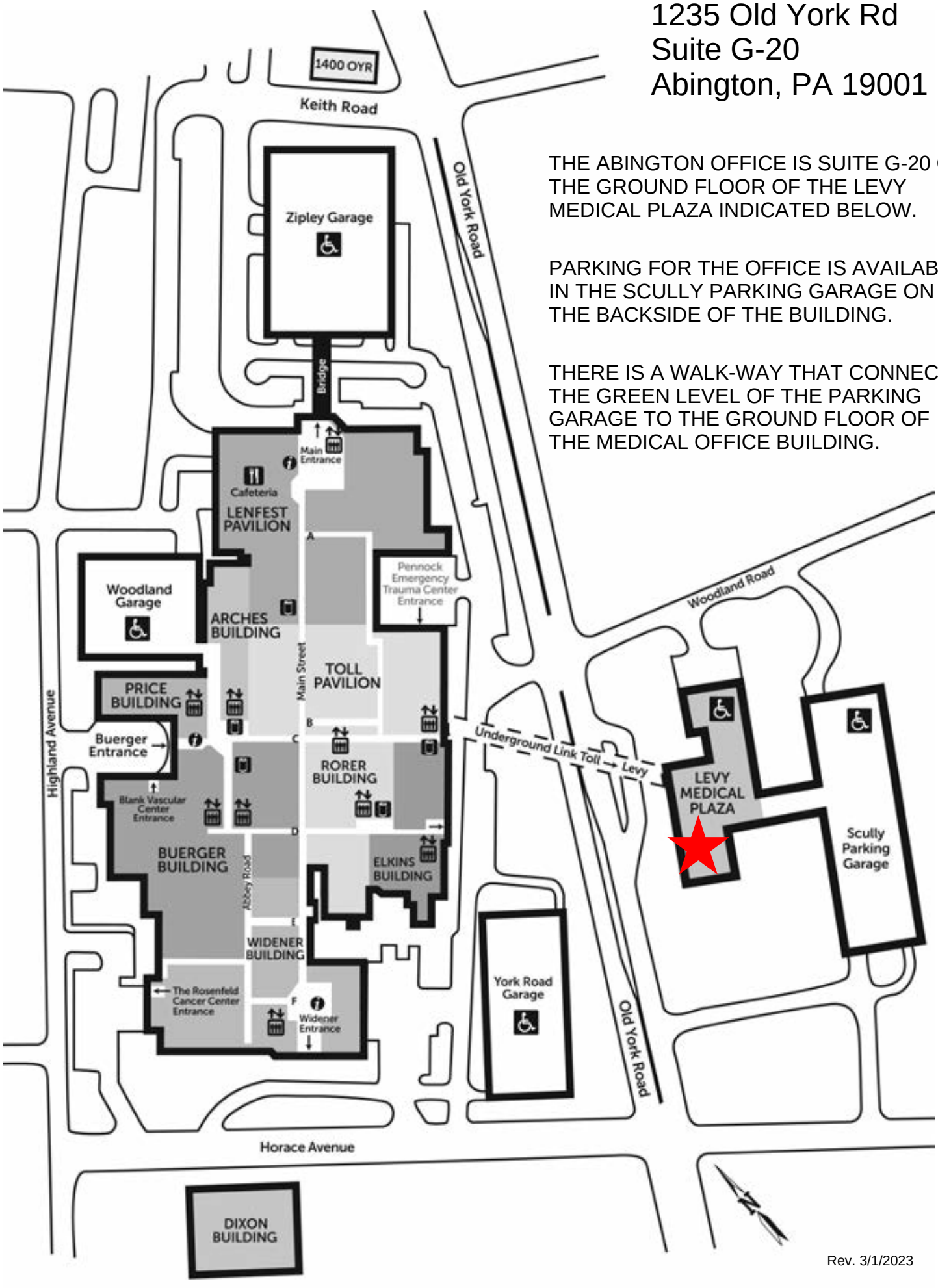
Rev: 5-29-2025

Levy Medical Plaza,
1235 Old York Rd
Suite G-20
Abington, PA 19001

THE ABINGTON OFFICE IS SUITE G-20 ON THE GROUND FLOOR OF THE LEVY MEDICAL PLAZA INDICATED BELOW.

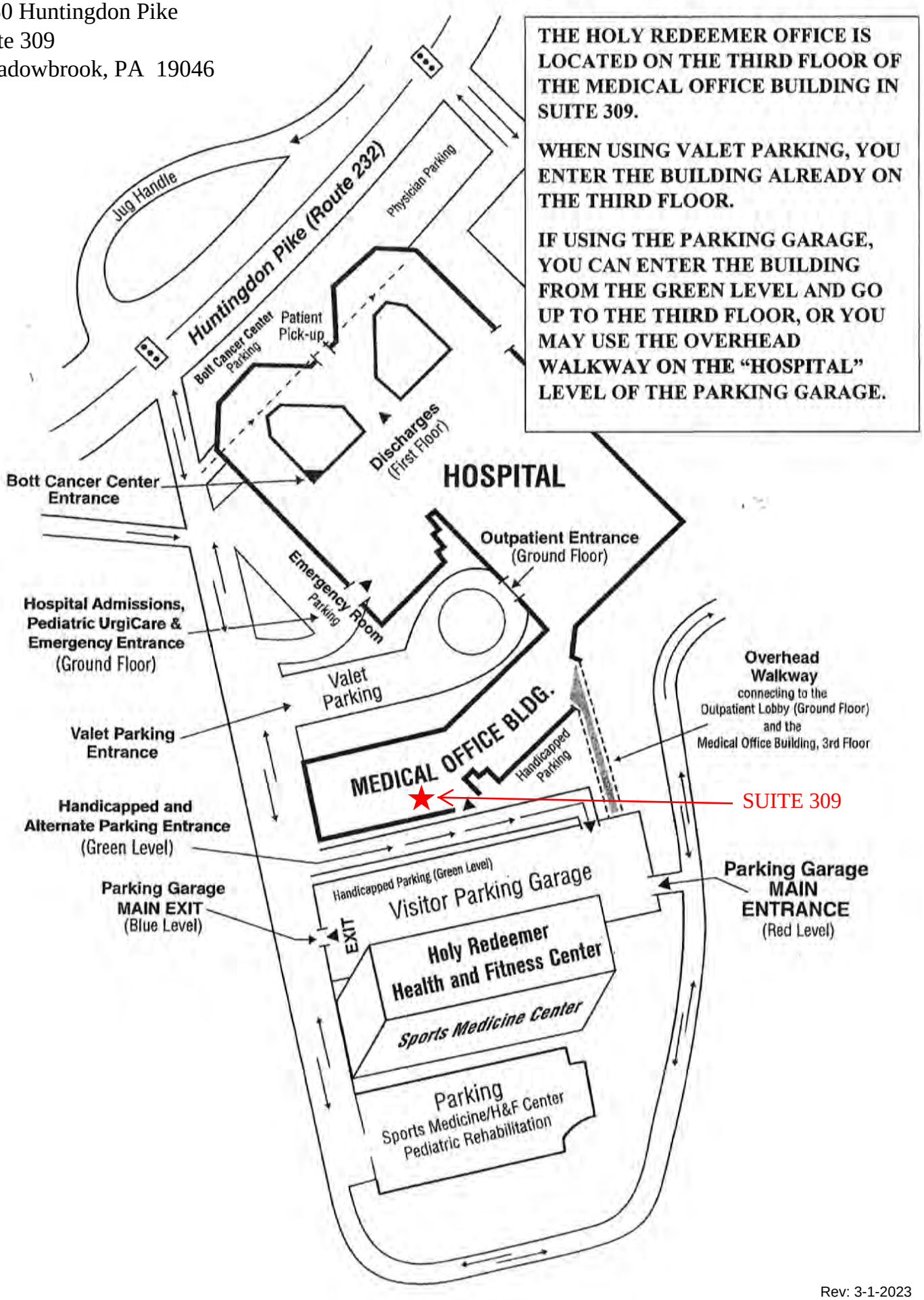
PARKING FOR THE OFFICE IS AVAILABLE IN THE SCULLY PARKING GARAGE ON THE BACKSIDE OF THE BUILDING.

THERE IS A WALK-WAY THAT CONNECTS THE GREEN LEVEL OF THE PARKING GARAGE TO THE GROUND FLOOR OF THE MEDICAL OFFICE BUILDING.



Rev. 3/1/2023

Holy Redeemer Medical Center
1650 Huntingdon Pike
Suite 309
Meadowbrook, PA 19046



Rev: 3-1-2023

COLON AND RECTAL ASSOCIATES, LTD
Joseph H. Nejman, M.D. | COLON AND RECTAL SURGERY | Steven A. Fassler, M.D.
Steven G. Harper, M.D. | PROCTOLOGY | Soo Y. Kim, M.D.
D. Mark Zebley, M.D. | David G. McKeown, 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 ☐ ETHINICITY: 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:**_____

By typing your name on the signature line, you agree with the terms and conditions of the document.

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

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)

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 ◯

Pulmonary System:

Yes ◯ No ◯ Asthma or emphysema

Yes ◯ No ◯ Pneumonia

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

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

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 <u>three or more relatives</u> 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, <u>before the age of 50</u>, 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 PRESCRIPTION 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:**_____

By typing your name on the signature line, you agree with the terms and conditions of the document.

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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

By typing your name on the signature line, you agree with the terms and conditions of the document.

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HEALTH INFORMATION EXCHANGE (HIE)

Health information exchange is the electronic sharing of health information between participating healthcare providers in a way that ensures the secure exchange of health information to provide care to patients.

Patient Information:

* Full Name: _____
* Date of Birth: _____
* Medical Record Number (if applicable): _____

☐ **Consent to Opt-In:**

I, _____, hereby voluntarily authorize the disclosure and receipt of information from my health record for the purpose of facilitating coordination of care and access to my health information by participating providers.

☐ **Optional Opt-Out:**

I, _____, hereby **opt-out** of the sharing of my health information with the HIE named above.

***PLEASE NOTE** - If you choose to Opt-out of the HIE, you are responsible for retrieving and providing any medical records or health information required by our practice for appropriate evaluation and treatment. This information must be received 24-48 hours prior to your scheduled appointment time. If the necessary medical records or health information are not received in the referenced time frame, your appointment may be rescheduled until they are provided. *

* Signature: _____
* Date: _____

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Billing Policy of Colon and Rectal Associates, LTD

Thank you for choosing Colon and Rectal Associates, LTD. Our mission is to exceed your expectations by providing high quality care and achieving patient satisfaction. Your health and well-being are 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 May 1, 2025 our billing policy will be as follows:

1. **All co-pays and prior balances are due in full at time of service in order to be seen.** Please contact your insurance company directly with any questions you may have regarding your financial obligation for specialist services.
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 the referral was issued. **Our NPI number is 1639124720**.
3. **At** This policy helps reduce administrative costs and supports our commitment to providing high-quality care. **Colon and Rectal Associates, LTD., we follow a Zero Balance Office policy to ensure a streamlined billing process and timely payment for services. All patient balances must be paid in full before additional services are provided. If your next appointment occurs before monthly statements are issued, our office will contact you to collect any outstanding balance. A copy of your statement is available upon request.** We encourage all patients to keep a valid credit, debit, or HSA card on file. This card will be used to promptly settle patient-responsible charges, including co-pays, deductibles, and any amounts determined by your insurance.
4. **Please be advised that we are not a participating provider for any Medicaid and/or state funded insurance plans. If you choose to have services with any of our physicians/providers, you will be responsible for the balance.**
5. **There will be a $50.00 fee for missed office appointments without prior notice. There will be a $250.00 fee for missed or canceled surgical procedures if 48 hours' notice is not provided.**
6. **There will be a $25.00 fee for the completion of all forms.**
7. **Payment plans are available, and require a valid credit, debit, or HSA card to be placed on file with our office.**

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

I have read and understand the Billing Policy of Colon & Rectal Associates, LTD. I agree to pay any balances due within 30 days, or before my next appointment, whichever comes first.

_____ _____

Patient signature Date

REV: 5-1-25

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Credit Card Authorization

Please Print Clearly

I, _____authorize,

Colon and Rectal Associates, LTD to charge my credit card for the balance of charges not paid by my insurance company.

Approximate Charges: To cover any deductibles, copay, co-insurance and /or non-covered services.

_____

Cardholder Signature Date

Patient Name: _____

Cardholder Name: _____

Cardholder Address: _____

City: _____ State: _____ Zip Code: _____

Type of card: (Visa, MasterCard, Discover, American Express)

Credit Card Number: _____

Expiration Date: _____

CVV Number: _____

Email Address: _____

Completed By: _____ Date: _____

REV: 5-1-25

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Patient Financial Responsibility Form/Self-Pay Waiver

Thank you for choosing Colon and Rectal Associates, LTD for your surgical care. This policy outlines our patients' financial obligations. The purpose is to streamline the billing process, ensure timely payment for services, and reduce administrative burdens, allowing us to focus on delivering quality healthcare.

Patient Financial Responsibilities

The patient (or patient's guardian, if a minor) is ultimately responsible for the payment of treatment and care. PLEASE CHECK THE APPROPRIATE BOX BELOW:

1. ☐ I agree to the **self-pay rate for services rendered, at the time of service.**
2. ☐ I elect to use available medical insurance for visit coverage.
    - We will bill your insurance for you, however the patient is required to provide the most correct and updated information regarding insurance.
    - Copayments are due at the time of service.
    - Patients are responsible for payment of co-pays, deductibles, and any amounts determined by your insurance.

You will be charged for any balance your insurance contract designates as your responsibility.

1. All patients are encouraged to place **a valid credit, debit or HSA card on file.** This policy helps reduce administrative costs and supports our commitment to providing high-quality care.
2. **Your balance must be paid in full prior to receiving additional services.**
3. **Please contact your insurance company directly to verify your financial responsibility before receiving services. Our staff cannot provide this information, as it is determined by your insurer based on your specific plan.**

By my signature below, 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. I also accept the fees charged as a legal and lawful debt and agree to pay said fees, including any/all collection agency fees, if such be necessary.

Patient Name: _____ **Date:** _____

Patient/Guardian Signature: _____

REV: 5-1-25