PATIENT REGISTRATION

Patient's Name _____ Date _____

Street Address_____ City _____ State & Zip _____

Home Phone (____) _____ Sex _____ Age _____ Date of Birth _____

Cell Phone (____)_____ Email Address _____ Race _____

Primary Language _____Employer _____ Occupation _____

Work Phone (____) _____ May we contact you at work? Y N

Referring Physician _____

Family Physician _____

Spouse's Name _____ Martial Status M S D W

Spouse's Occupation _____ Spouse's Birthday _____

Do you see any other specialists regularly *(cardiologist, pulmonologist, neurologist)*? Please list them here:

_____

_____

FOR COMMERCIAL INSURANCES: I hereby authorize the insurance company(ies) listed to pay directly to Regional Gastroenterology Associates of Lancaster, LLC d/b/a U.S. Digestive Health for services furnished to me; otherwise, payable to me under terms of my insurance. I hereby authorize photocopies of this authorization to be considered valid and effective as the original.

Patients Signature _____ Date _____

LIFETIME MEDICARE AUTHORIZATION: I authorize any holder of medical or other information about me to release to the Social Security Administration & Health Care Financing Administration or its intermediaries or Carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original & request payment of authorized Medicare benefits to be made to Drs. Markos, Lukaszewski, O'Connor, Nam, Sun, Jill Stauffer PAC, and Lauren Henry PAC. Regulations pertaining to Medicare assignment of benefits apply.

Patients Signature _____ Date _____

MEDIGAP: I request that payment of authorized Medigap benefits be made to either me or on my behalf to Drs. Markos, Lukaszewski, O'Connor, Nam, Sun, Jill Stauffer PAC, and Lauren Henry PAC for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release to _____ any information needed to determine these benefits payable for related services.

Patients Signature _____ Date _____

Patient Name _____
Patient DOB _____
Date_____

Medical History

Please check if you have a **personal** or **family** history of the following:

	PERSONAL	FAMILY *List family member*
Abnormal Liver Tests	☐	☐ _____
Anal Fissure	☐	☐ _____
Anemia	☐	☐ _____
Arrhythmia	☐	☐ _____
Arthritis	☐	☐ _____
Asthma	☐	☐ _____
Atrial Fibrillation	☐	☐ _____
Blood Clots	☐	☐ _____
Colon Cancer	☐	☐ _____
Colon Polyps	☐	☐ _____
Crohn's Disease	☐	☐ _____
Depression	☐	☐ _____
Diabetes	☐	☐ _____
Diverticulitis	☐	☐ _____
Emphysema	☐	☐ _____
Gall Stones	☐	☐ _____
Gallbladder Disease	☐	☐ _____
Gastro Esophageal Reflux	☐	☐ _____
Glaucoma	☐	☐ _____
Heart Disease	☐	☐ _____
Heart Valve	☐	☐ _____
Hemorrhoids	☐	☐ _____
Hepatitis	☐	☐ _____
Jaundice	☐	☐ _____
High Blood Pressure	☐	☐ _____
Irritable Bowel Syndrome	☐	☐ _____
Kidney Disease	☐	☐ _____
Liver Disease	☐	☐ _____
Pacemaker	☐	☐ _____
Pancreatitis	☐	☐ _____
Seizures	☐	☐ _____
Sleep Apnea	☐	☐ _____
Stroke	☐	☐ _____
Thyroid Disease	☐	☐ _____
Ulcer	☐	☐ _____
Ulcerative Colitis	☐	☐ _____

Do you have any of the following symptoms?

	Yes	No
Abdominal Pain	☐	☐
Poor Appetite	☐	☐
Bloating/Belching	☐	☐
Difficulty Swallowing	☐	☐
Heartburn	☐	☐
Nausea	☐	☐
Vomiting	☐	☐
Regurgitation	☐	☐
Change in Bowel Habits	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Black, Tarry Stools	☐	☐
Rectal Bleeding	☐	☐
Recent Weight Change	☐	☐
Bleeding/Bruising	☐	☐
Fatigue	☐	☐
Fever	☐	☐
Blurred or Double Vision	☐	☐
Hearing Loss	☐	☐
Ear Ringing	☐	☐
Mouth Sores	☐	☐
Nose Bleeds	☐	☐
Chest Pain	☐	☐
Swelling of Ankles	☐	☐
Cough	☐	☐
Wheezing	☐	☐
Shortness of Breath	☐	☐
Joint Pain	☐	☐
Rash/Itching	☐	☐
Headaches	☐	☐
Memory Loss	☐	☐
Confusion	☐	☐
Feeling of Depression	☐	☐
Feeling of Anxiety	☐	☐
Blood in Urine	☐	☐

Patient Name _____
Patient DOB _____
Date_____

Other Personal Medical History _____

Other Family Medical History _____

List any surgeries you have had and the year of the surgery _____

_____

During any surgical procedure, have you been told you have difficult intubation? _____

Have you been diagnosed with Cancer? If so, please list site and when you were diagnosed _____

_____

Have you ever had an Upper Endoscopy? If so, what year? _____

Have you ever had a colonoscopy? If so, what year?_____

Have you ever had a flexible sigmoidoscopy? If so, what year? _____

Do you Have tattoos? _____ Have you ever been given a blood transfusion? _____

What is your daily caffeine intake? _____ Do you drink alcohol? _____

Do you smoke? _____ If no, have you ever? _____ Do you use IV/Street Drugs? _____

Signature _____ Date _____

THE BOXES BELOW ARE FOR OFFICE USE ONLY

Are there any changes to your medical history since your past visit? Y N

If so, what are they? _____

Signature _____ Date _____

Are there any changes to your medical history since your past visit? Y N

If so, what are they? _____

Signature _____ Date _____

Are there any changes to your medical history since your past visit? Y N

If so, what are they? _____

Signature _____ Date _____

Patient Name _____
Patient DOB _____
Date_____

Medication List

Pharmacy Name & Number _____ _____

Pharmacy Address _____

Allergies: _____ Please check here if none _____

Are you taking any blood thinners? (Examples: Coumadin, Warfarin, Plavix, Pradaxa, Xarelto, Brilinta, Effient, Aspirin) YES _____If Yes, please specify below NO _____

Blood Thinners _____

If you do not take any medications, please check here _____

Please list any prescribed and over the counter vitamins or supplements you are currently taking below:

MEDICATION	DOSAGE (MG)	HOW OFTEN TAKEN	REASON FOR MEDICATION

Site: CGI

Consent to Treat/Assignment of Benefits

Patient Name: _____ Date of Birth: _____

I understand and agree that Regional Gastroenterology Associates of Lancaster, LLC d/b/a U.S. Digestive Health may provide treatment to me and may use and disclose protected health information about me for treatment, payment and/or health care operations.

I authorize the release of any medical information necessary to process my claims to the insurance companies/carriers listed in my file . I authorize and assign payment of medical benefits on my behalf directly to Regional Gastroenterology Associates of Lancaster, LLC d/b/a U.S. Digestive Health. A copy of this authorization will be as valid as the original.

_____ _____

Signature of Patient or Authorized Representative Date

_____

Relationship to Patient

Site: CGI

Financial Policy

Patient Name: _____ Date of Birth: _____

Thank you for choosing Regional Gastroenterology Associates of Lancaster, d/b/a U.S. Digestive Health (USDH). USDH is committed to providing you with the best care possible, while minimizing your out-of-pocket expenses and making the payment of any private balances as easy as possible. In order to do this, our financial department will need your assistance and your understanding of our financial policy. Please read and sign this Financial Policy prior to your treatment.

We participate with most major insurance plans, including Medicare. If you are not insured by a plan with which we participate, payment in full is expected at each visit. If you are insured by a plan in which we participate, but you do not provide up-to-date insurance information, you will be considered self-pay until insurance coverage can be confirmed. It is your responsibility to know your insurance benefits. Please contact your insurance company with any coverage questions.

All patients must complete our patient registration process before seeing the physician or provider. We will need a copy of your identification card and a current valid health insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim.

Insurance:
For your convenience we will submit claims to your insurance carrier for payment provided we are contracted with your chosen insurance. We will submit to primary, secondary and supplemental plans as needed.

It is your responsibility to provide USDH with current, accurate billing information at the time of your visit and to notify us of any changes in the information. If the information provided is inaccurate or inactive, you will be considered self-pay for services.

Co-payments are due at the time services are provided. This is a contractual agreement you have with your health plan and our contractual obligation with participating insurance carriers. If payments are not made at time of service, there may be a Co-Pay Billing Fee. USDH accepts cash, checks, debit cards and major credit cards. Returned checks are subject to a reasonable processing fee.

Referrals:
It is your responsibility to determine if you require a referral before your appointment. If you arrive without a referral and one is needed, you may be asked to either pay for your appointment in full before being seen or to reschedule your appointment pending the referral.

Pre-Authorizations:
USDH will obtain precertification for any services that require pre-authorization. Pre-authorization does not guarantee that the service will be covered or paid by your insurance carrier. Precertification is the process of notifying the insurance carrier of certain treatment services you will receive so the insurance carrier can determine medical necessity.

Our relationship is with the patient, not the insurance carrier. While pre-authorizations, referrals and the filing of insurance claims is a courtesy extended to our patients, all charges are your responsibility. If you disagree with a bill from our office, please contact your insurance company as the first step to determine the reason for any balance or non-coverage of a service. It is the patient's responsibility to contact their insurance carrier prior to treatment and service to determine specific guidelines for coverage, deductibles and co-pays based on your individual coverage.

Self-Pay:
You are expected to pay a minimum deposit of $65.00 for all office visits which will be applied to your total charge for services that day. Self-Pay discounts are offered and applied to your balance. Remaining balances paid within 30 days of the date of service are eligible for an additional prompt payment discount. If at any time you are unable to pay a balance due, please contact our office for assistance or to establish a payment plan.

Balances:
You have a financial responsibility to pay for any services received at USDH. This includes co-pays, co-insurance, deductibles, non-covered services and self-pay fees. Please understand that that if payment or a payment plan is not established after issuance of three statements, the balance on the account may be placed with a collection agency. Reasonable costs associated with collection efforts will be your responsibility.

I understand that I am financially responsible for any co-pays, co-insurance, deductibles, non-covered services and self-pay fees. I have read and understand this Financial Policy and by signing I accept all terms and conditions described above.

No Show and Cancellation Policy:
Last minute cancellations and no-shows prevent other patients from receiving necessary treatment and creates an added expense for the Practice and physician. To promote efficient access to our services, we request that you notify us at least 24 hours in advance if you cannot keep your appointment. In the event that an appointment is missed or cancelled with less than 24- hour notice, a $25.00 charge will be billed to your account.

_____ _____
Signature of Patient or Authorized Representative Date

Relationship to Patient: _____

Notice of Privacy Practices Acknowledgement

Patient Name: _____ Date of Birth: _____

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used for treatment, payment and healthcare operations.

By signing this form, I acknowledge that I have viewed and have been offered a copy of U.S. Digestive Health's "Notice of Privacy Practices" ("NPP"). This NPP describes in detail how we might use or disclose your protected health information.

I understand that this organization has the right to change its NPP from time to time and I my request a copy of the NPP at any time or review it on the company website.

I am aware that I may request a copy of the NPP at any time and that a current version of the NPP is available at www.USDigestiveHealth.com under "Privacy Policy".

_____ _____

Signature of Patient or Authorized Representative Date

_____

Relationship to Patient

If Applicable

The patient refused or was unable to acknowledge the Notice of Privacy Practices (please indicate reason: _____

_____

_____

_____ _____

Staff Representative Signature Date

Non-Discrimination Notice

U.S. Digestive Health (USDH) and its affiliates comply with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. USDH does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender, sexual orientation or gender identity. We provide free aids and services to people with disabilities to communicate effectively including:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact the Practice Administrator for this location.

If you believe that USDH has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

U.S. Digestive Health
Privacy Officer
707 Eagleview Blvd, Suite 100
Exton, PA 19341
Email: Compliance@usdhealth.com
Phone: 610-234-7922

You can file a grievance in person or by mail, email or telephone. If you need help filing a grievance, the Practice Administrator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.
or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Spanish - ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-215-257-5071 (TTY: 711)

Chinese - 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-215-257-5071（TTY: 711)

Vietnamese - CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-215-257-5071 (TTY: 711)

Russian - ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-215-257-5071 (телетайп: 711).

Pennsylvania Dutch - Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-215-257-5071 (TTY: 711).

Korean - 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-215-257-5071 (TTY: 711)번으로 전화해 주십시오.

Italian - ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-215-257-5071 (TTY: 711).

Arabic

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1--257-215 5071

(رقمArab هاتف الصم و-711).

French - ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-215-257-5071 (ATS : 711).

German - ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-215-257-5071 (TTY: 711).

Gujarati - સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-215-257-5071 (TTY: 711).

Polish - UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-215-257-5071 (TTY: 711).

French Creole - ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-215-257-5071 (TTY:711).

Cambodian - ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-215-257-5071 (TTY: 711)។

Portuguese - ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-215-257-5071 (TTY: 711).

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs,such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference betweenwhat your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you isyour plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protectionsnot to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balancebill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

Pennsylvania also provides partial balance billing protections to limit billing amounts to in-network cost sharing amounts for emergency services and most health care professionals.

When balance billing isn't allowed, you also have the followingprotections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

- Your health plan generally must:

    - Cover emergency services without requiring you to get approval for services inadvance (prior authorization).

    - Cover emergency services by out-of-network providers.

    - Base what you owe the provider or facility (cost-sharing) on what it would pay anin-network provider or facility and show that amount in your explanation of benefits.

    - Count any amount you pay for emergency services or out-of-network servicestoward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact either the location at which the services were provided or our toll-free billing customer service line at 1-877-543-9753. You may also contact our Compliance Department by email at Compliance@usdhealth.com or call the USDH corporate office at 610-234-7900 for assistance.

Visit No Surprises: Understand your rights against surprise medical bills | CMS for more information about your rights under federal law.

Visit Regular Session 2019-2020 Senate Bill 0822 P.N. 1128 (state.pa.us) for more information about your rights under [state laws].]