

# DIGESTIVE DISEASE AND NUTRITION CENTER OF WESTCHESTER, LLP.

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Dear New Patient,

Welcome to Our Office!!! Patients are the lifeblood of our practice. In today's day and age where so much of health care revolves around insurance companies and HMOs, we want you to know that in our office patients come first. Due to the continuing changes in the healthcare industry we would like to provide you with our practice billing policies and how they relate to you. We are experts in gastroenterology and nutritional care, not insurance. We will help you if we can; however, it is ultimately your responsibility to know your insurance policy.

Our office currently participates in the following insurance companies: (Please note this list is subject to change)

Aetna	Benesight	GEHA	Medicare	Performax
A.U.S.A	BlueCross / BlueShield	GHI	Metropolitan Empire	PHCS
AH & L	Cigna	Greatwest	Multiplan	Pomco
Amalgamated	Claimtech	H.I.P.	N. American Admin.	Travelers Medicare
American Group Admin.	Connecticare	Healthnet – PHS	Oxford	Unicare
Amerihealth	Eastern Benefits	INDECS	Palmetto GBA	United Healthcare
Anthem	Firsthealth	Greatwest	All traditional indemnity insurances	
Beech Street	Gallagher Bassett	Magnacare	MSAs; Flex Spending Accts	

**LAB WORK & HOSPITAL PROCEDURES:** Please be advised that many insurance companies require you to go to a certain lab and/or hospital. YOU will be responsible to pay your bill if you go to a lab and/or hospital that is not covered by your insurance carrier. Please check with your insurance company to see where you should go for these services.

**NON PARTICIPATING INSURANCE CARRIERS:** We will file the claim if you provide us with the following information: Name and mailing address of your insurance carrier, policy number, group number, policy holders' full name, policy holders' date of birth and social security number. We file these claims as a courtesy to our patients so that your insurance carrier reimburses you in a timely manner. We will bill your insurance company only once per service, the responsibility of the service remains the patient's responsibility. The patient is responsible to pay the bill within 30 day of the service date.

**INSURANCE'S THAT REQUIRE REFERRALS:** If you have an insurance company that requires a referral from your primary care physician, it is the patient's responsibility to obtain the voucher and keep track of its expiration. We will be unable to see you for scheduled appointments if we do not have the voucher on/or before the date of the appointment, however, if you would like to be seen, if your visit is not covered, you will be responsible for any payments at the time of service.

**CO-PAYS:** If you have an insurance that requires a patient co-payment, it must be paid at the time of the service. If a co-payment is not paid at the time of service an office service charge of \$10 dollars may be applied to your balance.

**NUTRITION ONLY PATIENTS:** As per guidelines of many insurance companies, if you solely have a weight problem with no other associated medical problems i.e. cholesterol, heart condition, high blood pressure, arthritis, etc., you may not be covered and will be responsible for your associated fees. Please see a billing department staff member with any questions.

**PATIENTS WITHOUT INSURANCE:** Payment must be made at the time of the service unless an acceptable payment plan has been agreed upon with the billing staff prior to the services rendered.

If you are unable to make your appointment please kindly call us 24 hours in advance, our staff will be more than happy to assist you, as a charge may be imposed if a cancellation is not made the day before.

We welcome you to our practice and look forward to providing your medical care. If you ever have a concern, complaint, complement or suggestion, please feel free to inform your physician or myself by calling (914) 683-1555. We sincerely hope that your relationship with us will be beneficial and that you will look forward to a long and happy relationship with us.

Sincerely,

Richard Rosemarin  
Chief Operating Officer  
The Digestive Disease & Nutrition Center of Westchester, LLP



**DIGESTIVE DISEASE & NUTRITION**  
**CENTER OF WESTCHESTER, LLP**  
*Excellence in Gastroenterology and Nutrition for over 25 years*

**PATIENT REGISTRATION**

LEGAL NAME: \_\_\_\_\_  
LAST FIRST MIDDLE INITIAL BIRTHDATE

BILLING ADDRESS: \_\_\_\_\_  
STREET CITY/STATE ZIP

HOME PHONE #: \_\_\_\_\_ CELL PHONE #: \_\_\_\_\_ WORK PHONE #: \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_ MARITAL STATUS: \_\_\_\_\_ SEX: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_ DRIVER LICENSE : \_\_\_\_\_

PRIMARY CARE PHYSICIAN: \_\_\_\_\_ REFERRING PHYSICIAN: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_  
NAME PHONE RELATION

E-MAIL ADDRESS: \_\_\_\_\_

**HOW DID YOU HEAR ABOUT US?** PRIMARY CARE PHYSICIAN REFERRING PHYSICIAN PATIENT REFERRAL INSURANCE DIRECTORY  
YELLOW PAGES ONLINE SEARCH/WEBSITE I'M A PREVIOUS PATIENT OTHER: \_\_\_\_\_

**PARENT OR GUARDIAN INFORMATION (IF APPLICABLE)**

NAME: \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_ SEX: \_\_\_\_\_  
LAST FIRST MIDDLE INITIAL

SOCIAL SECURITY #: \_\_\_\_\_ MARITAL STATUS: \_\_\_\_\_ IS PARENT/GUARDIAN A PATIENT @ DDNCW? Y / N

ADDRESS: \_\_\_\_\_  
STREET CITY/STATE ZIP

HOME PHONE #: \_\_\_\_\_ CELL PHONE #: \_\_\_\_\_ WORK PHONE #: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

**PRIMARY INSURANCE**

INSURANCE NAME: \_\_\_\_\_ SUBSCRIBER NAME: \_\_\_\_\_ INSURANCE PHONE: \_\_\_\_\_

CLAIMS ADDRESS: \_\_\_\_\_  
STREET CITY/STATE ZIP

MEMBER ID #: \_\_\_\_\_ GROUP #: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

**SECONDARY INSURANCE**

INSURANCE NAME: \_\_\_\_\_ SUBSCRIBER NAME: \_\_\_\_\_ INSURANCE PHONE: \_\_\_\_\_

CLAIMS ADDRESS: \_\_\_\_\_  
STREET CITY/STATE ZIP

MEMBER ID #: \_\_\_\_\_ GROUP #: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

**PATIENT ACKNOWLEDGEMENT**

The above information is true to the best of my knowledge.

\_\_\_\_\_  
SIGNATURE: (Must be 18 or over)

\_\_\_\_\_  
Date



# DIGESTIVE DISEASE & NUTRITION CENTER OF WESTCHESTER, LLP

Excellence in Gastroenterology and Nutrition for over 25 years

## HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

<b>Name</b> (Last, First, M.I.):		<input type="checkbox"/> M <input type="checkbox"/> F	<b>DOB:</b>
<b>Previous or referring doctor:</b>		<b>Date of last physical exam:</b>	
<b>Reason For today's Visit:</b>		<b>Today's Date:</b>	
<b>PERSONAL HEALTH HISTORY</b>			

<b>Childhood illness:</b>	<input type="checkbox"/> Measles	<input type="checkbox"/> Mumps	<input type="checkbox"/> Rubella	<input type="checkbox"/> Chickenpox	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Polio
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<b>Immunizations and dates:</b>	<input type="checkbox"/> Tetanus	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Influenza	<input type="checkbox"/> Pneumonia
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<b>List any medical problems that other doctors have diagnosed</b>

<b>Surgeries / Hospitalizations</b>		
Year	Reason	Hospital

<b>Have you ever had a blood transfusion?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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<b>List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers</b>		
Name the Drug	Strength	Frequency Taken

<b>Allergies</b>	
Name the Drug or Chemical	Reaction You Had

### HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

<b>Exercise</b>	<input type="checkbox"/> Sedentary (No exercise)			
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)			
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)			
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)			
<b>Diet</b>	Are you dieting?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, what program are you on?			
	Rank fat intake	<input type="checkbox"/> Hi	<input type="checkbox"/> Med	<input type="checkbox"/> Low
<b>Caffeine</b>	<input type="checkbox"/> None	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea	<input type="checkbox"/> Cola
	# of cups/cans per day?			
<b>Alcohol</b>	Do you drink alcohol?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	How many drinks per week?			
	Are you concerned about the amount you drink?			<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Tobacco</b>	Do you use tobacco?			<input type="checkbox"/> Yes <input type="checkbox"/> NA
	<input type="checkbox"/> Cigarettes – pks./day	<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day	<input type="checkbox"/> Cigars - #/day
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit		

## FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
<b>Father</b>			<b>Mother</b>		
<b>Sibling</b>	<input type="checkbox"/> M <input type="checkbox"/> F		<b>Children</b>	<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F	

### MENTAL HEALTH

Is stress a major problem for you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel depressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you panic when stressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have problems with eating or your appetite?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you cry frequently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever attempted suicide?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever seriously thought about hurting yourself?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have trouble sleeping?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been to a counselor?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

### WOMEN ONLY

Date of last menstruation:		
Period every _____ days		
Number of pregnancies _____ Number of live births _____		
Heavy periods, irregularity, spotting, pain, or discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you pregnant or breastfeeding?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any urinary tract, bladder, or kidney infections within the last year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any hot flashes or sweating at night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Experienced any recent breast tenderness, lumps, or nipple discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

### MEN ONLY

Do you usually get up to urinate during the night?	If yes, # of times _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel pain or burning with urination?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any blood in your urine?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel burning discharge from penis?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had any kidney, bladder, or prostate infections within the last 12 months?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any difficulty with erection or ejaculation?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any testicle pain or swelling?		<input type="checkbox"/> Yes	<input type="checkbox"/> No

### OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.			
<input type="checkbox"/> Skin	<input type="checkbox"/> Chest/Heart	<input type="checkbox"/> Throat	<input type="checkbox"/> Recent changes in:
<input type="checkbox"/> Head/Neck	<input type="checkbox"/> Back	<input type="checkbox"/> Bowel	<input type="checkbox"/> Weight
<input type="checkbox"/> Ears	<input type="checkbox"/> Intestinal	<input type="checkbox"/> Lungs	<input type="checkbox"/> Energy level
<input type="checkbox"/> Nose	<input type="checkbox"/> Bladder	<input type="checkbox"/> Circulation	<input type="checkbox"/> Ability to sleep
<input type="checkbox"/> Other pain/discomfort:			

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



# DIGESTIVE DISEASE & NUTRITION

## CENTER OF WESTCHESTER, LLP

*Excellence in Gastroenterology and Nutrition for over 25 years*

### PATIENT AGREEMENT & FINANCIAL POLICY

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

#### OFFICE POLICIES:

##### OFFICE POLICIES:

(Initial) \_\_\_\_\_

**MEDICAL APPOINTMENTS:** We ask for 2 days notice to reschedule or cancel appointments. This courtesy allows us to schedule another patient in your place. If an emergency arises, please give us as much notice as possible. Failure to show up to a scheduled appointment, without a cancellation phone call, will be subjected to a \$50 No Show Fee.

We ask that new patients arrive fifteen minutes early to fill out paperwork. When a patient is more than 10 minutes late, we reserve the right to shorten or reschedule the appointment, if needed, to not inconvenience other patients.

**RETURNED CHECK FEE:** There is a \$50 returned check fee for any checks returned to us by the bank.

##### INSURANCE COVERAGE

(Initial) \_\_\_\_\_

**REFERRALS:** It is your responsibility to bring any required referrals for treatment at, or prior to, the time of your visit. If you do not have a referral, your visit will be rescheduled, or you may be financially responsible.

**INSURANCE CARD:** Please bring your insurance card as you must present your insurance card at the time of your appointment. Without the presence of an insurance card, you will need to pay in full at the time of service. We will provide you with a receipt which you may submit to your insurance company yourself.

**COPAYS:** All copays are due at the time of service. If we have to bill you for a copay, there will be a \$10.00 billing fee.

**NONCOVERED SERVICES:** Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.

**PERSONAL INJURY CASES:** This office does not bill for auto accident or other liability or lawsuit-related cases. You are responsible for payment at the time of service. We do not accept liens.

**OTHER:** You are responsible for paying your annual deductible, co-payment and charges for any non-covered, cosmetic services. Patients who are covered by private, commercial plans in which our physicians are not providers are responsible for the entire unpaid balance left after payment from your insurance, regardless of the benefits and payment policies of your carrier.

**ASSIGNMENT OF INSURANCE BENEFITS:** I hereby authorize the release of medical information to my primary care or referring physicians, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

##### MEDICARE PATIENTS

(Initial) \_\_\_\_\_

**SIGNATURE ON FILE:** I request payment of authorized Medicare benefits be made either to me or on my behalf to the Digestive Disease & Nutrition Center of Westchester, LLP for any services furnished me by the listed provider/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

##### PRIVACY PRACTICES

(Initial) \_\_\_\_\_

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

By My signature below I acknowledge receipt of the Notice of Privacy Practices and have read the above financial policies.

\_\_\_\_\_  
SIGNATURE (Must be 18 or over)

\_\_\_\_\_  
DATE