Hinsdale Gastroenterology Associates, SC

ROBERT C. JANDA, MD   ROBERT M. LEE, MD
PETER L. SERAPHIN, DO   ERIN DOWNES, PA-C
12 Salt Creek Lane, Suite 425
Hinsdale, IL 60521
Ph (630)789-2260
Fx (630)789-1584

PATIENT INFORMATION

NAME____TODAY'S DATE________________

BIRTHDATE_____/_______/______________   SEX: ☐ M   ☐ F

ADDRESS______________________________CITY/STATE_______________________ZIP________

Please place an "X" next to your primary contact number.   ☐ HOME PHONE (______)________________________

☐ WORK PHONE (______)____________________ ☐ CELL PHONE (______)________________________

MARITIAL STATUS   S   M   D   SEP   W   IF MARRIED, SPOUSE'S NAME________________________

EMERGENCY CONTACT______________________RELATIONSHIP_________ PHONE (______)______________

PRIMARY CARE PHYSICIAN______________________________ PHONE (______)____________________

REFERRING PHYSICIAN (if different than PCP)_________________________ PHONE (______)______________

PHARMACY NAME_______________________________ PHONE (______)_________________________

ADDRESS______________________________CITY/STATE_______________________ZIP________

E-Mail Address____________________________ Are you interested in using our Patient Portal? ☐ Yes   ☐ No

INSURANCE INFORMATION

PRIMARY INSURANCE
NAME OF INSURED______________________________
RELATIONSHIP TO PATIENT______________________
POLICY / ID #________________________________
GROUP #_____________________________________
INSURED'S BIRTHDATE__________________________
INSURANCE CO NAME____________________________
☐ HMO ☐ PPO ☐ POS

SECONDARY INSURANCE
NAME OF INSURED______________________________
RELATIONSHIP TO PATIENT______________________
POLICY / ID #________________________________
GROUP #_____________________________________
NSURED'S BIRTHDATE___________________________
INSURANCE CO NAME____________________________
☐ HMO ☐ PPO ☐ POS

TURN OVER

Hinsdale Gastroenterology Associates, SC
12 Salt Creek Lane Suite 425 Hinsdale, Illinois 60521
Ph (630)789-2260 Fx (630)789-8540

SIGNATURE PAGE

PERSONAL MEDICAL HISTORY AND HEALTH FORM

I certify that I have given information that is complete, accurate, and current in the Hinsdale Gastroenterology Associates Personal Medical History and Health Questionnaire.

___________ Initial

NOTICE OF PRIVACY PRACTICES

Hinsdale Gastroenterology Associates, SC may use and disclose protected health information for treatment, payment and healthcare operations. Examples of these include, but are not limited to, referral to other providers for treatment, requested life insurance physicals, referral to nursing homes, home health agencies. Payment examples include, but are not limited to, insurance companies for claims including coordination of benefits with other insurers; collection agencies; pre-certification of treatment. Healthcare operations include, but are not limited to, internal quality control and assurance including auditing of records. Hinsdale Gastroenterology Associates, SC is permitted or required to use or disclose protected health information without the individual's written consent or authorization in certain circumstances. Our practice utilizes electronic verification of insurance eligibility and prescription benefits. At your request, a copy of our notice of privacy practices in its entirety is available for review. By signing below I acknowledge that I have been informed of Hinsdale Gastroenterology Associates, SC Notice of Privacy Practices.

___________ Initial

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize the release of any medical information to my insurance carrier requested and required to expedite the processing of my insurance claim/s for services rendered by Hinsdale Gastroenterology Associates. Furthermore, I authorize payment of the claim to the provider of said services: Robert Janda, MD, Robert Lee, MD, Peter Seraphin, DO, Erin Downes, PA-C. If my insurance carrier required that I obtain a referral form or pre-certification for any services requested, I understand that it is my responsibility to contact my insurance carrier or my primary care physician to obtain the appropriate authorization. I understand that I am financially responsible for charges incurred for services rendered. I am responsible for the co-insurance, co-pay, deductible or denial of coverage amounts according to the terms of my health insurance policy.

___________ Initial

MEDICAL RECORDS AND BILLING ISSUES

The following people are allowed to receive my medical information and discuss billing issues on my behalf.

	Records only	Billing only	Both
Name/s: ______________________ ☐ Spouse ☐ Parent/s ☐ Children ☐ Other	☐	☐	☐
Name/s: ______________________ ☐ Spouse ☐ Parent/s ☐ Children ☐ Other	☐	☐	☐

___________ Initial

PATIENT Signature Acknowledgement

X______________________________	______________	______________
Signature of Patient or Personal Representative	Relationship	Date
______________________________	______________	______________
Signature of Patient or Personal Representative	Relationship	Date