

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)789-8540

PATIENT INFORMATION

NAME _____ TODAY'S DATE _____

BIRTHDATE _____ SEX: M F

ADDR _____ CITY/STATE _____ ZIP _____

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

WORK PHONE (_____) _____ CELL PHONE (_____) _____

MARITAL STATUS S M D SEP W IF MARRIED, SPOUSE'S NAME _____

EMERGENCY CONTACT _____ PHONE (_____) _____

REFERRING PHYSICIAN _____ PHONE (_____) _____

PHARMACY NAME _____ PHONE (_____) _____

ADDRESS _____ CITY/STATE _____ ZIP _____

INSURANCE INFORMATION

If we have scanned your insurance card or you have provided a copy of the front and back of your insurance card,
you **do not** have to complete this section.

PRIMARY INSURANCE

INSURANCE CO NAME _____

POLICY/ID# _____

GROUP# _____

SECONDARY INSURANCE

INSURANCE CO NAME _____

POLICY/ID# _____

GROUP# _____

EMPLOYER INFORMATION

PATIENT'S EMPLOYER

NAME _____

ADDR _____

PHONE (_____) _____

INSURED'S EMPLOYER (If different from patient's employer)

NAME _____

ADDR _____

PHONE (_____) _____

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 C. Janda, MD, Robert M. Lee, MD, Peter L. Seraphin, DO. 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: _____ <input type="checkbox"/> Spouse <input type="checkbox"/> Parent/s <input type="checkbox"/> Children <input type="checkbox"/> Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Name/s: _____ <input type="checkbox"/> Spouse <input type="checkbox"/> Parent/s <input type="checkbox"/> Children <input type="checkbox"/> Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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_____ **Initial**

PATIENT Signature Acknowledgement

<p>X _____</p> <p>Signature of Patient or Personal Representative</p>	<p>_____</p> <p>Relationship</p>	<p>_____</p> <p>Date</p>
<p>_____</p> <p>Signature of Patient or Personal Representative</p>	<p>_____</p> <p>Relationship</p>	<p>_____</p> <p>Date</p>