Hillmont GI / Springfield ASC
PATIENT REGISTRATION FORM

Please PRINT CLEARLY so we can read your information accurately. Thank you.

SOCIAL SECURITY #:_____

NAME:_____

ADDRESS:_____ **CITY:**_____ **ST:**_____ **ZIP:**_____

HOME PHONE:_____ **WORK PHONE:**_____ **CELL PHONE:**_____

GENDER: ○ Male / ○ Female **DATE OF BIRTH:**_____

EMPLOYER:_____ **EMPLOYER PHONE #:**_____

EMPLOYER ADDRESS:_____ **CITY:**_____ **ST:**_____ **ZIP:**_____

E-MAIL ADDRESS:_____ *(for you to access your health information electronically)*

PRIMARY PHYSICIAN:_____ **PHONE NUMBER:**_____

REFERRING PHYSICIAN:_____ **PHONE NUMBER:**_____

MARITAL STATUS: ○ Single ○ Married ○ Partnered ○ Widowed

EMERGENCY CONTACT #1:_____ **PHONE:**_____ **RELATIONSHIP:**_____

EMERGENCY CONTACT #2:_____ **PHONE:**_____ **RELATIONSHIP:**_____

PHARMACY:_____ **PHARMACY PHONE #:**_____

PHARMACY ADDRESS:_____ **CITY:**_____ **ST:**_____ **ZIP:**_____

FOR GOVERNMENT HEALTHCARE ANALYSIS USE

RACE (Only check one selection):

○ American Indian or Alaska Native
○ Asian
○ Black or African-American
○ More than one race
○ Native Hawaiian
○ Other Pacific Islander
○ White
○ Do not wish to provide

ETHNICITY (Only check one selection):

○ Hispanic or Latino
○ Not Hispanic or Latino
○ Do not wish to provide

PRIMARY / PREFERRED LANGUAGE (Only check/write one selection):

○ Chinese
○ Korean
○ Other:_____
○ English
○ Spanish
○ Hindi
○ Vietnamese
○ Do not wish to provide
○ Italian
○ American Sign Language

PRIMARY INSURANCE INFORMATION

INSURANCE CO. NAME:_____

○ **The insured policyholder is the patient**

(if under spouse, fill in spouse's name and date of birth)

Insured's Name:_____

Insured Date of Birth:_____

Insured's Social Security #:_____

SECONDARY INSURANCE INFORMATION

INSURANCE CO. NAME:_____

○ **The insured policyholder is the patient**

(if under spouse, fill in spouse's name and date of birth)

Insured's Name:_____

Insured Date of Birth:_____

Insured's Social Security #:_____

AUTHORIZATION FOR RELEASE OF INFORMATION & ASSIGNMENT OF BENEFITS

COMMERCIAL INSURANCE PATIENTS: I AUTHORIZE the release of any medical information necessary to process my insurance claims. I AUTHORIZE and request payment of medical benefits directly to my physicians. I AGREE that authorization will cover all medical services rendered until such authorization is revoked by me. I AGREE that a photocopy of this form may be used in place of the original.

SIGNATURE:_____ **DATE:**_____

MEDICARE PATIENTS: I AUTHORIZE any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services (CMS) 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 and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I UNDERSTAND it is mandatory to notify the healthcare provider of any other party who may be responsible for paying for my treatment. Regulations pertaining to Medicare assignment of benefits also apply.

SIGNATURE:_____ **DATE:**_____

ALL PATIENTS: OK to share your protected health information? **YES** / **NO** (circle one). If YES, please list the following:

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

SIGNATURE:_____ **DATE:**_____

TO ALL PATIENTS: HIPAA NOTICE
HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT

I acknowledge that I have received our Notices of Privacy Practices Brochure:

SIGNATURE:_____ **DATE:**_____

Hillmont GI / Springfield ASC
Medical History Form

Name:_____ **DOB:**_____ **Age:**_____ **Today's Date:** _____

Occupation:_____ **Marital Status:**_____

Reason for Visit:_____

Height: ____ feet ____ inches **Weight:** _____ pounds

Do you have a living will/advanced directive? Yes No Please provide a copy at your next visit

Family History (include relation if applicable):

Colon Cancer:_____ Colon polyps:_____

Ulcerative Colitis or Crohn's Disease: _____ Liver Disease:_____

Medications/Dose/Frequency (include over-the-counter drugs):

_____

_____

_____

Allergies to medications, latex or IV dye:_____

Any previous reactions to anesthesia:_____

Blood Thinner Treatment: Coumadin/Warfarin Plavix Aspirin

Do you smoke? Yes No # of packs per day:____ / # of years smoke:____ / Quit?:_____

Do you use alcohol? Yes No # of drinks per week:____

History of excessive alcohol use:_____

History of drug/substance abuse:_____

Prior Surgical History (list all operations):

_____

_____

Heart Attack	Angina	Pacemaker	Coronary Blockages
Congestive Heart Failure	Irregular Heart Rhythm	Artificial Valve	Heart Valve problems
Stent or Angioplasty	Bypass	Defibrillator	Bleeding Problems
Diabetes	High Blood Pressure	Stroke/TIA	Asthma
COPD/Emphysema	Sleep Apnea	Home Oxygen	Kidney disease
Kidney dialysis	Thyroid disease	Lupus	Sarcoid
HIV	Hepatitis B or C	Pancreatitis	Anemia
Anxiety/Depression	Bipolar disorder	Rheumatoid arthritis	
Prior blood transfusion	History of Cancer:_____		

Which of the following are you experiencing? Please check either 'Yes' or 'No'

Constitutional		
Recent weight change	No	Yes
Fever	No	Yes
Fatigue	No	Yes
Eyes		
Blurred vision	No	Yes
Glaucoma	No	Yes
Ears/Nose/Mouth/Throat		
Hearing loss	No	Yes
Ringing in the ears	No	Yes
Mouth sores	No	Yes
Cardiovascular		
Chest pain	No	Yes
Shortness of breath	No	Yes
Swelling of the ankles	No	Yes
Respiratory		
Chronic cough	No	Yes
Spitting up blood	No	Yes
Wheezing	No	Yes
Genitourinary		
Burning when urinating	No	Yes
Blood in urine	No	Yes
Musculoskeletal		
Joint pain or swelling	No	Yes
Back pain	No	Yes
Muscle pain	No	Yes
Skin		
Rash	No	Yes
Itching	No	Yes

Gastrointestinal		
Poor appetite	No	Yes
Swallowing difficulty	No	Yes
Heartburn	No	Yes
Nausea/Vomiting	No	Yes
Bloating	No	Yes
Belching	No	Yes
Regurgitation	No	Yes
Constipation	No	Yes
Diarrhea	No	Yes
Abdominal pain	No	Yes
Recent change in bowel habits	No	Yes
Rectal bleeding	No	Yes
Black, tarry stools	No	Yes
Blood in stools	No	Yes
Neurological		
Headaches	No	Yes
Seizures	No	Yes
Strokes	No	Yes
Numbness	No	Yes
Psychiatric		
Memory loss or confusion	No	Yes
Depression/Anxiety	No	Yes
Endocrine		
Heat or cold intolerance	No	Yes
Excessive thirst	No	Yes
Excessive urination	No	Yes
Hematological		
Bleeding/bruising tendency	No	Yes
Anemia	No	Yes
Blood transfusion	No	Yes
Are you pregnant?	No	Yes

How did you hear about us?_____

Patient's Signature:_____

Revised 9/16/2013

HILLMONT GI, PC

1811 Bethlehem Pike, Building C, Suite 300, Flourtown, PA 19031 Phone: 215.402.0800
125 Medical Campus Drive, Suite 104, Lansdale, PA 19446 Phone: 215.997.9377
Victor Araya, MD – Gerald Bertiger, MD – Robert Boynton, MD – Steven Nack, MD – Benjamin Raile, MD – James Taterka, MD
FAX: (215) 836-2429

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Please Note: Copy Fee May Be Charged For Medical Records

NAME:_____ **DATE OF BIRTH:**_____

ADDRESS:_____ **CITY:**_____ **ST:**_____ **ZIP:**_____

HOME PHONE:_____ **CELL PHONE:**_____

Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified. I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. This information may be disclosed and used by the following individual organization:

RELEASE TO NAME/ORGANIZATION: Hillmont GI, PC

ADDRESS: 1811 Bethlehem Pike **CITY:** Flourtown **STATE:** PA **ZIP:** 19031

FAX NUMBER: 215-836-2429 **PHONE:** 215-402-0800

DATES AND TYPE OF INFORMATION TO DISCLOSE:

- ☐ Complete Records
- ☐ Procedure Reports
- ☐ Consultations
- ☐ Radiology or Laboratory Reports
- ☐ Other:_____

THE PURPOSE OF DISCLOSURE IS:

- ☐ Change of Insurance or Physician
- ☐ Continuation of Care
- ☐ Referral
- ☐ Other:_____

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire one year from the date signed. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE:_____**DATE:**_____

IF SIGNED BY LEGAL REPRESENTATIVE, PRINT NAME & RELATIONSHIP:_____

For Internal Use Only: Date Received: _____ Date PHI Sent: _____ Date Completed:_____

FINANCIAL POLICY
For Hillmont GI, Springfield ASC & Anesthesia Services

Hillmont GI is dedicated to providing you the most efficient care and service possible. **Your understanding of our financial policy is an essential element of your care and service**. The following is a statement of our Financial Policy, which we require you to read and sign prior to treatment. If you have questions regarding our policy, please feel free to contact our billing department at 215-402-0800 ext 226.

Full payment is due at the time of service. HMO and other "managed care" plans require that primary care physicians provide the patient with a referral to be presented to the specialty care physician. This form must specify a request for a consultation or for treatment, and reason for the referral. **If your insurance company requires a referral and you do not bring a referral with you, we will reschedule your visit**. If you have insurance, and have signed an "Assignment of Benefits" statement, we will bill your insurance carrier for you if we are a provider on your plan. Outstanding balances after insurance are due within (30) days of the billing statement date. **Any balance unpaid after ninety days will be turned over to our collection agency Northwest Collectors, Inc. unless other arrangements are made with our billing department.**

It is your responsibility to know the details of your particular insurance policy. **Not all services are covered by all insurance carriers**. Services and diagnosis which are not covered by your insurance are your responsibility. Diagnoses and services are carefully documented to comply with federal law. Under no circumstances will these be changed, altered or falsified in ordered to obtain coverage by insurance. If your insurance has a **copay** it is due at the time of service. It is against the law for us to waive a copay. If we do not collect them your insurance company can charge us with billing fraud. If you have a **deductible**, you are responsible for all charges until the deductible is met.

If your insurance carrier has a **"network**" of providers it is your responsibility to make sure we are an "in network" provider prior to obtain services. If we are not "in network", we will still be happy to provide services: however the percentage of charges or deductible for which you are responsible will be greater.

It is your responsibility to make sure we have accurate insurance carrier information and billing information. If a claim is unsuccessful because of flawed insurance or billing information, you will be responsible for the balance.

We will make every effort to assist you in understanding the above information. We will also assist with any problems arising with your insurance to the extent we can accommodate.

Disclosure of Springfield Ambulatory Surgery Center Ownership

I have been informed that the physician who is rendering services to me may have an ownership interest in Springfield Ambulatory Surgery Center. The physician has given me the option to be treated at another facility, which I have declined. I wish to be treated at the Springfield Ambulatory Surgery Center.

_____ _____

Signature Date

SPRINGFIELD AMBULATORY SURGERY CENTER

PATIENT RIGHTS & NOTIFICATION OF OWNERSHIP

As a patient of the **Springfield Ambulatory Surgery Center,** you have the right to receive the following information in advance of the date of the procedure.

PATIENT'S BILL OF RIGHTS:

Every patient has the right to be treated as an individual with his/her rights respected. The facility and medical staff have adopted the following list of patient's rights.

Patient Rights:

•To receive respectful, considerate and dignified care given by competent personnel.
•To be provided, upon request, the name of his/her attending practitioner, the names of all other practitioners directly participating in his/her care, and the names and functions of other health care persons having direct contact with the patient.
•The right to have records pertaining to his/her medical care treated as confidential, except as otherwise provided by law.
•The opportunity to approve or refuse release of his/her medical care records prior to submission to any party, including third parties based on contractual arrangements, except as otherwise provided by law.
•Consideration of privacy concerning his own medical care program. Case discussion, consultation, examination and treatment are considered confidential and shall be conducted discreetly.
•To expect emergency procedures to be implemented without unnecessary delay.
•The right to know what ambulatory care facility rules and regulations apply to his/her conduct as a patient.
•To be given the opportunity to participate in decisions involving his/her health care, except when such participation is contraindicated for medical reasons.
•to good quality care and high professional standards that are continually maintained and reviewed.
•to full information in layman's terms, concerning diagnosis, evaluation, treatment and prognosis, including information about alternative treatments and possible complications. When it is not medically advisable to give the information to the patient, the information shall be given on his behalf to the responsible person.
•Except in cases of emergency, the practitioner shall obtain the necessary informed consent prior to the start of the procedure.
•A patient, or if unable to give informed consent, a person responsible to the patient, has the right to be advised when a practitioner is considering the patient as a part of a medical care research program or donor program, and the patient, or responsible person shall give informed consent prior to actual participation in the program. A patient or responsible person may refuse to continue in a program to which he or she has previously given informed consent.
•The right to refuse the participation of Center in the patient's treatment.
•Right to refuse drugs or procedures, to the extent permitted by statute, and a practitioner shall inform the patient of the medical consequences of the patient's refusal of drugs or procedures.
•to medical and nursing services without discrimination based upon age, race, color, religion, gender, national origin, handicap, disability or source of payment.
•A patient who does not speak English or is deaf shall have access, when necessary, to interpretation services.
•A patient who is blind or deaf shall have alternative communicative assistance available to them, if requested.
•Shall have access to the information contained in his/her medical records at the ambulatory care facility, unless the attending practitioner for medical reasons specifically restricts access.
•To expect good management techniques to be practiced within the ambulatory care facility. Techniques shall make effective use of the patient's time and shall avoid personal discomfort of the patient.
•To be transferred when an emergency occurs to another facility and requires transfer to a location capable of providing emergency services, with notification to both patient or their responsible party and the facility prior to the patient's transfer.
•To examine and receive a detailed explanation of his/her bill.
•To expect that the ASF will provide information for continuing health requirements following discharge and the means for meeting them.
•The right, without recrimination, to voice comments, suggestions, complaints and grievances regarding care; to have those complaints reviewed and when possible, resolved; and when not resolved, to obtain information regarding external appeals, as required by state and Federal law and regulations.
•To be informed verbally and in writing, in terms the patient could understand, of his/her rights, responsibilities, and expected conduct by the ambulatory care facility at the time of admission.
•The right to information covering services available at the ASF, the fees related to those services, and the payment policies governing restitution for services rendered.
•The right to information on the provision of after hours and emergency services for care and treatment rendered at the ASF.
•The right to information on advance directives, as required by state or Federal law and regulations**.** Advance Directives will not be honored within the Center. In the event of a life-threatening event emergency medical procedures will be implemented. Patients will be stabilized and transferred to a hospital where the decision to continue or terminate emergency measures can be made by the physician and family.
If the patient or patient's representative wants their Advance Directives to be honored, the Patient will be offered care at another facility that will comply with their wishes.
If you request, an official state Advance Directive Form will be provided to you
•The right to be provided, upon request, information pertaining to the process of credentialing of the practitioners rendering care and treatment at the ASF.
•The right not to be misled by the organization's marketing or advertising regarding their competence and capabilities.
•To obtain names, addresses, and telephone numbers from the Center Director of the governmental offices were complaints may be lodged.
•To obtain names, addresses and telephone numbers of offices where information concerning Medicare and Medicaid coverage can be obtained.
The following are the names and/or agencies you may contact:

Patricia Hebert (Center Director)
Springfield Ambulatory Surgery Center
1528 Bethlehem Pike
Flourtown, PA 19031
215-402-0600

You may contact your state representative to report a complaint:

Pennsylvania Department of Health website:
www.health.state.pa.us

Sites for address and phone numbers of regulatory agencies:
Complaint Hotline: 1-800-254-5164

Medicare Ombudsman website
www.medicare.gov/Ombudsman/resources.asp

Medicare: www.medicare.gov or
call 1-800-MEDICARE (1-800-633-4227)

Office of the Inspector General: http://oig.hhs.gov

Physician Financial Interest and Ownership:

The Center is owned, in part, by the physicians. The physician(s) who referred you to this Center and who will be performing your procedure(s) may have a financial and ownership interest. Patients have the right to be treated at another health care facility of their choice. We are making this disclosure in accordance with Federal regulations.

By signing below, you, or your legal representative, acknowledge that you have received, read and understand this information (verbally and in writing) in advance of the date of the procedure and have decided to have your procedure performed at this center.

_____,
hereby acknowledge receipt of the Patient Rights & Notification of Ownership.

Signed:_____
Date:_____

PLEASE BRING THIS FORM WITH YOU ON THE DAY OF YOUR PROCEDURE

Notice of Privacy Practices
Hillmont G.I., PC

WELCOME!

We are pleased to provide you with this information about how we protect the privacy and confidentiality of information about you **(Patient Health Information)** and how we use and disclose your Patient Health Information.

Patient Health Information includes symptoms, test results, diagnoses, treatment, and related medical information. It also includes appointment, billing, payment, and insurance information. (Under some circumstances we may be required by law to use or disclose the information even without your permission).

We Use and Disclose Your Patient Health Information:

For treatment purposes to bill and obtain payment for the services rendered, for evaluation of your care including consultation with other healthcare professionals and necessary communication with laboratories, radiologists, pharmacies, and family member participation in your care, etc.

When required by law we report gunshot wounds, suspected neglect or abuse, or similar injuries and events, also, in response to a subpoena or court order, and (subject to certain restrictions) in response to requests by law enforcement officials.

For public health activities such as collection of vital statistics, identifying diseases, recalls related to dangerous products, and similar information to public health authorities. We also supply information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.

For health oversight to assist in investigations and audits, and to determine eligibility for government programs, insurance programs, etc.

For approved medical research.

To avoid threats to your health or safety or to that of another person or the general public.

As required by military or special government agencies like the armed forces and correctional institutions or for national security purposes.

For requests from Worker's Compensation, or similar programs providing benefits.

For routine communications, like mailings or phone calls, for example billing statements, appointment reminders/changes and recall notices. We may ask that test results be sent to our office. We may also discuss test results that we ordered or treatment outcome follow-ups. Information and alternatives about your treatment or other health related benefits or services that may be of interest to you might be sent/given to you. In such instances the envelopes or fold-over postcards we send <u>will not</u> have our office name as the return address. Instead that address will

be either “125 Medical Campus Drive, Suite 104” or “Flourtown Commons, Bldg. C, Suite 300”. In any other situation we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign a disclosure authorization you may revoke that authorization. You may request a list of instances which disclose health information about you, if any, for reasons other than treatment, payment or healthcare operations.

YOUR RIGHTS

You have the following rights with regard to your health information. Please contact the person listed at the end of this brochure to exercise these rights.

You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions.

You have the right, in most cases, to review or obtain a copy of your health information. We may charge you a small fee for making copies. You have the right to request that we **amend** or **correct** information.

Complaints

If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the person indicated at the end of this brochure. You may also send a letter to the U.S. Department of Health and Human Services. The person indicated at the end of this brochure will provide you with the appropriate address. You will not be penalized in any way for filing a complaint.

OUR LEGAL DUTY

We are required by law to protect and maintain the privacy of your health information and to provide you with the notice currently in effect. We may change our policies at any time. All significant changes will be stated in a revised document. A notice of the revision will be posted in the waiting area. Also, copies of the revised statement will be available at the check-out window.

Privacy Issues Contact Person

If you have any questions, requests, or complaints, please contact our designated Privacy Officer by writing to:

Privacy Officer
Hillmont G.I., PC
1811 Bethlehem Pike, Suite C-300
Flourtown, PA 19031

Revised 1/8/2014

Directions to Lansdale Office

Hillmont GI, p.c.

125 Medical Campus Drive Suite 104
Phone: 215-997-9377 Fax: 215-997-8891
Office Hours: 7:40am- 4:40pm
Phones opened Daily: 9:00am- 5:00pm

From Route 309 South: Allentown/Quakertown
Take Route 309 south to Colmar. Make a right turn onto Broad Street. Stay on Broad Street for approximately 1-1/2 mile and make a left turn onto Medical Campus Drive.

From Route 309 North: Philadelphia
Take Route 309 north to Cowpath Rd/PA-463. Continue straight for 1.4 miles and turn left onto N. Broad St. Continue 0.7 mile and make left turn onto Medical Campus Dr.

From the Northeast Extension, Pennsylvania Turnpike
Take the Northeast Extension (Route 476) of the Pennsylvania Turnpike to the Lansdale Exit (#31). After leaving the tollbooths, make a left turn onto Sumneytown Pike. Go straight on Sumneytown Pike almost three miles and turn left onto Broad Street. Continue on Broad Street for approximately 1.0 mile and make right turn onto Medical Campus Drive.

From Route 202 South: Doylestown
Take Route 202 south to the five-point intersection in Montgomeryville, where routes 202, 309 and 463 intersect. Make right turn onto Route 463 (Cowpath Road). Go approximately 1.4 miles to traffic light at Broad Street. Turn left and continue 0.7 mile and make left turn onto Medical Campus Drive.

From Route 76 (Schuylkill Expressway): Center City Philadelphia
Take Route 76 west to the Plymouth Meeting/Conshohocken – Route 476 north Exit. Take the Northeast Extension (Route 476) to the Lansdale Exit (#31), approximately 15 miles. After leaving the tollbooths, make a left turn onto Sumneytown Pike. Go straight on Sumneytown Pike almost three miles and turn left onto Broad Street. Continue on Broad Street for approximately 1.0 mile and make right turn onto Medical Campus Drive.

From Philadelphia International Airport
Take Interstate 95 south to Route 476 north. Follow the signs to the Northeast Extension, Pennsylvania Turnpike – Route 476 north. Take the Northeast Extension to the Lansdale Exit (#31). After leaving the tollbooths, make a left turn onto Sumneytown Pike. Go straight on Sumneytown Pike almost three miles and turn left onto Broad Street. Continue on Broad Street for approximately 1.0 miles make a right turn onto Medical Campus Drive.