Northwell Health | Digestive Health Center of Huntington

195 East Main Street, Huntington, New York 11743 | (631) 385-8677 | www.dhchuntington.com

PATIENT INFORMATION

Name: _____ SS#: _____-_____-_____ Birth Date: _____/_____/_____ Age: _____
Last First MI

Sex: _____ Marital Status: [ ] Single [ ] Married [ ] Widowed [ ] Divorced

Ethnicity: [ ] Hispanic [ ] Non-Hispanic

Race: [ ] White [ ] Asian: _____ (Specify, if known - e.g., Chinese)
[ ] Black/African American [ ] Native Hawaiian or Pacific Islander
[ ] American Indian or Alaskan Native [ ] Other: _____ (Please describe)

Phone (_____) _____- _____ Work Phone (_____) _____-_____
Area Code Area Code

Address: _____
Street City State Zip

Emergency Contact Person: _____
Name Phone Relationship

Patient's Employer: _____ Occupation: _____

Employer's Address: _____
Street City State Zip

All professional services are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. Please be advised that we will submit to your primary and secondary. Any remaining balance after receipt of explanation of benefits from your primary and secondary insurance carrier will be billed to you.

INSURANCE AUTHORIZATION AND ASSIGNMENT

NAME OF POLICY HOLDER: _____

I request that payment of authorized Medicare/ other insurance company benefits be made either to me on my behalf or to the Digestive Health Center of Huntington for any services furnished me by that third party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply.
I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers and information needed for this or a related Medicare claim/other Insurance company 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 health care provider of any other party who may be responsible for paying for my treatment. (Section1128B of the Social Security Act and 31 U.S.C 3801-3812 provides penalties for withholding this information).

_____ _____
Signature of Patient or Responsible Party Date

LABORATORY TESTING

During the course of your procedure it may be necessary for your physician to obtain and send tissue samples, blood samples, or request other laboratory testing. The State of New York now requires clinical laboratories to directly bill patients for their testing services, or that person's legal representative. Therefore, it is necessary for the Digestive Health Center of Huntington to receive authorization from the patient in order for us to allow the laboratory to bill your insurance company for you. If you do not want the laboratory to bill your insurance company, then billing for the services will go directly to you as the patient.
Please complete and sign below so that we may direct this issue in the proper manner.
Thank you for your cooperation with this matter.

[ ] Yes, I am giving the laboratory permission to bill my insurance company.

[ ] No, I do not give the laboratory permission to bill my insurance company. I am aware that I am responsible for payment of services directly to the laboratory

_____ _____
Signature of Patient or Responsible Party Date

REGISTRATION

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Patient Interview Form

Patient Information

Patient Name: _____ DOB: _____

Email: _____ ☐ Personal Email | ☐ Work Email

Sex: ☐ Male ☐ Female ☐ Other _____ ☐ Unknown

Allergies

☐ Patient has no known allergies ☐ Patient has no known drug allergies
Food: ☐ Sulfites ☐ Shellfish ☐ Eggs ☐ Soybeans
Medication: ☐ Penicillins ☐ Sulfa ☐ Other _____

Reaction(s):_____

Consent to Import Medication History
I consent to obtaining a history of my medications purchased at pharmacies
☐ Yes ☐ No

Current Medications ☐ None

Name	Dosage	Last Taken

*If more space is needed, please continue on page 4.

Diagnostic Studies/Tests
☐ None
☐ Previous Colonoscopy | When: _____
☐ Previous EGD | When: _____

Past or Present Medical Conditions ☐ None

Gastroenterology	◯ Diverticulitis	◯ Diverticulosis	◯ Colon polyp history	◯ Colon cancer
	◯ Crohn's Disease	◯ Ulcerative Colitis	◯ Irritable Bowel Syndrome	◯ Gastroesophageal Reflux Disease (GERD)
	◯ Barrett's Esophagus	◯ Celiac Disease	◯ Bowel Obstruction	◯ Fatty Liver
	◯ Cirrhosis	◯ Hepatitis B	◯ Hepatitis C	◯ Pancreatitis
	◯ Gastric Ulcer	◯ Hiatal hernia	Other:	
Cardiology	◯ Congestive Heart Failure	◯ Coronary Artery Disease	◯ Heart Attack	◯ Heart Murmurs
	◯ Mitral Valve Prolapse/MR	◯ High blood pressure	◯ High Cholesterol	◯ Atrial Fibrillation
	◯ Pacemaker/ Defibrillator	◯ Stroke	◯ Transient Ischemic Attack	◯ Coronary Artery Stents
	Other:			
Pulmonology	◯ Asthma	◯ Sleep apnea	◯ C.O.P.D.	Other:
Other	◯ Arthritis	◯ Breast cancer	◯ Cataracts	◯ Bleeding disorder
	◯ Diabetes Mellitus, Insulin Dependent (Type 1)	◯ Diabetes Mellitus, Non-Insulin Dependent (Type 2)	◯ Glaucoma	◯ Hyperthyroidism
	◯ Hypothyroidism	◯ HIV infection	◯ Kidney disease	◯ Kidney stones
	◯ Lung cancer	◯ Ovarian Cancer	◯ Prostate Cancer	◯ Seizures
	◯ Skin Cancer	Other:		

Previous Procedures ☐ None

◯ Cholecystectomy (Gallbladder removal)	◯ Appendectomy	◯ Tonsillectomy	◯ Colectomy (Colon Resection)	◯ Small Bowel Resection
◯ Bariatric Surgery	◯ Hemorrhoid banding	◯ Hemorrhoidectomy	◯ Coronary Artery Bypass Graft (CABG)	
◯ Hernia Repair - Inguinal/Umbilical	◯ Hysterectomy- Partial/Total	◯ Abdominal aortic aneurysm (AAA) repair	◯ Heart valve replacement	◯ Spinal Surgery
◯ Joint Replacement	◯ Mastectomy L Breast	◯ Mastectomy R Breast	◯ Vasectomy	◯ Bilateral Tubal Ligation (BTL)
◯ C Section	◯ Infusion Port Placement	◯ Cardiac Cath - with stent placement	◯ Cataract Surgery	Other:

Social History

Caffeine ☐ None ☐ 1 Cup Daily ☐ 2 of More Cups Daily

Alcohol ☐ None ☐ Occasionally ☐ Daily

Tobacco/Smoking Status

☐ Current Every Day Smoker ☐ Current Some Day Smoker ☐ Former Smoker ☐ Never
☐ Smoker, Current Status Unknown ☐ Light Tobacco Smoker ☐ Heavy Tobacco Smoker
☐ Type of Cigarettes _____ Quantity_____ Frequency_____

Drug Use ☐ None ☐ Recreational Type_____ Frequency _____

Exercise ☐ None ☐ Yes Type_____ Frequency _____

Review of Systems

Cardiovascular	Y	N
◯ None		
chest pain	◯	◯
dyspnea with exercise	◯	◯
irregular heart beat	◯	◯
orthopnea	◯	◯
palpitations	◯	◯
peripheral edema	◯	◯
syncope	◯	◯

Gastrointestinal	Y	N
◯ None		
abdominal pain	◯	◯
abdominal swelling	◯	◯
change in bowel habits	◯	◯
constipation	◯	◯
diarrhea	◯	◯
gas	◯	◯
heartburn	◯	◯
jaundice	◯	◯
nausea	◯	◯
rectal bleeding	◯	◯
stomach cramps	◯	◯
vomiting	◯	◯
difficulty swallowing	◯	◯

Neurological	Y	N
◯ None		
dizziness	◯	◯
fainting	◯	◯
frequent headaches	◯	◯
migraine	◯	◯
numbness or tingling	◯	◯
seizures	◯	◯
tremors	◯	◯
vertigo	◯	◯
memory loss	◯	◯

Respiratory	Y	N
◯ None		
asthma	◯	◯
cough	◯	◯
dyspnea	◯	◯
excessive sputum	◯	◯
coughing up blood	◯	◯
shortness of breath with exercise	◯	◯
wheezing	◯	◯

Reviewed With

☐ Patient ☐ Parent ☐ Guardian ☐ Not Present

Signature

_____

Patient Signature Date

Current Medications ☐ None

Name	Dosage	Last Taken

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Dear Patient,

Welcome to the Digestive Health Center of Huntington!

Notice to all Patients

Because of concerns that there may be conflict of interest when a physician refers a patient to a healthcare facility in which the physician has a financial interest, The Center for Medicare and Medicaid along with New York State has passed certain criteria for disclosure to the patients scheduled for procedures at the Digestive Health Center.

The condition set forth is that I disclose this financial interest. This disclosure is intended to help you make a fully informed decision regarding your healthcare. If you require any other information regarding alternative providers, please consult the staff of Digestive Health Center. In addition to Northwell Health, the following physicians have a financial interest in the Endoscopy Center of Long Island: Paul Bermanski MD, Richard Fried MD, David Purow MD, Owen Su MD, Mark Dobriner MD, and Zvi Alpern MD.

Advanced Directive Policy

- Digestive Health Center of Huntington is an outpatient surgery center that is limited to elective surgery only and performs no high-risk surgical procedures.
- It is the policy of Digestive Health Center of Huntington to recognize the Health Care Agent of the patient should circumstances require, but in the event of an emergency the patient will be stabilized and transferred to a hospital as soon as possible.
- Therefore, the Digestive Health Center of Huntington will not acknowledge DNR (Do Not Resuscitate) orders on any patient while in this Ambulatory Surgical Center. For information on advance directives, reference: http://www.noah-health.org/en/rights/endoflife/adforms.html

Billing Information

Please Be advised that the Digestive Health Center of Huntington, Inc. (DHC), an article 28 Ambulatory Endoscopy Center. We will verify your insurance benefits prior to your procedure but there may be information not available to us as the rendering facility. Information given is not a guarantee of payment. Please be sure to call your insurance carrier prior to your procedure to review your plan and understand if there is any patient financial responsibility such as copayments, deductibles, and co-insurance. If you have any questions, please contact our billing department by calling 631-385-8677.

THE PATIENT HAS THE FOLLOWING RESPONSIBLITIES:

1. To provide the Center, to the best of their ability, with complete and accurate information about your health, any medications you take, including over the counter products and dietary supplements, and any allergies or sensitivities.
2. To ask all questions you may have regarding the treatment provided by the Center.

3. To consent by free will to all procedures.
4. To tell us if you do not understand procedures or instructions.
5. To follow the treatment plan prescribed by your doctor and to participate in your care.
6. To provide a responsible adult to transport you to and from the Center. This person should be available to you for 24 hours following the procedure, if required by your doctor.
7. To contact his/her physician with post-testing questions or concerns.
8. To provide all necessary information regarding third-party payment sources and to accept personal financial responsibility for any charges not covered by your insurance
9. To observe all the Center's policies and regulations and to be respectful of the Center's providers and staff, as well as to other patients.
10. To keep appointments as scheduled or advise the Center if the appointment cannot be kept.

PATIENT COMPLAINT OR GRIEVANCE:

If you have a complaint or grievance against the center, please speak with a member of our care team. If necessary, your complaint will be escalated to the Administrator, Bret Hoffman, for review. Upon review, you will be contacted to inform you of the resolution. Bret can be reached by phone at 631-385-8677 or by email at BHoffman@DHCHuntington.com.

If you have any complaints about the exercise of your rights, you may contact the New York State Department of Health, Courthouse Corporate Center, 320 Carleton Avenue, Suite 5000, Central Islip, NY 11722 or you may call them at 631-851-4300.

In addition, you may also contact the AAAHC by mail at AAAHC, Inc. 5250 Old Orchard Road, Suite 200, Skokie, IL 60077.

All Medicare beneficiaries may also contact the Office of the Medicare Beneficiary Ombudsman at its website: www.cms.hhs.gov/center/ombudsman.asp if they wish to file a complaint or grievance.

Patients' Bill of Rights for Diagnostic & Treatment Centers (Clinics)

As a patient in a Clinic in New York State, you have the right, consistent with law, to:

(1) Receive service(s) without regard to age, race, color, sexual orientation, religion, marital status, sex, gender identity, national origin or sponsor;

(2) Be treated with consideration, respect and dignity including privacy in treatment;

(3) Be informed of the services available at the center;

(4) Be informed of the provisions for off-hour emergency coverage;

(5) Be informed of and receive an estimate of the charges for services, view a list of the health plans and the hospitals that the center participates with; eligibility for third-party reimbursements and, when applicable, the availability of free or reduced cost care;

(6) Receive an itemized copy of his/her account statement, upon request;

(7) Obtain from his/her health care practitioner, or the health care practitioner's delegate, complete and current information concerning his/her diagnosis, treatment and prognosis in terms the patient can be reasonably expected to understand;

(8) Receive from his/her physician information necessary to give informed consent prior to the start of any nonemergency procedure or treatment or both. An informed consent shall include, as a minimum, the provision of information concerning the specific procedure or treatment or both, the reasonably foreseeable risks involved, and alternatives for care or treatment, if any, as a reasonable medical practitioner under similar circumstances would disclose in a manner permitting the patient to make a knowledgeable decision;

(9) Refuse treatment to the extent permitted by law and to be fully informed of the medical consequences of his/her action;

(10) Refuse to participate in experimental research;

(11) Voice grievances and recommend changes in policies and services to the center's staff, the operator and the New York State Department of Health without fear of reprisal;

(12) Express complaints about the care and services provided and to have the center investigate such complaints. The center is responsible for providing the patient or his/her designee with a written response within 30 days if requested by the patient indicating the findings of the investigation. The center is also responsible for notifying the patient or his/her designee that if the patient is not satisfied by the center response, the patient may complain to the New York State Department of Health;

(13) Privacy and confidentiality of all information and records pertaining to the patient's treatment;

(14) Approve or refuse the release or disclosure of the contents of his/her medical record to any health-care practitioner and/or health-care facility except as required by law or third-party payment contract;

(15) Access to his/her medical record per Section 18 of the Public Health Law, and Subpart 50-3. For additional information link to: http://www.health.ny.gov/publications/1449/section_1.htm#access;

(16) Authorize those family members and other adults who will be given priority to visit consistent with your ability to receive visitors;

(17) When applicable, make known your wishes in regard to anatomical gifts. Persons sixteen years of age or older may document their consent to donate their organs, eyes and/or tissues, upon their death, by enrolling in the NYS Donate Life Registry or by documenting their authorization for organ and/or tissue donation in writing in a number of ways (such as health care proxy, will, donor card, or other signed paper). The health care proxy is available from the center;

(18) View a list of the health plans and the hospitals that the center participates with; and

(19) Receive an estimate of the amount that you will be billed after services are rendered.

Patients' Rights, 10NYCRR, Section 751.9

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RECEIPT OF INFORMATION

I have read, reviewed, and understand the information on the documents noted below which I received prior to my procedure at Digestive Health Center of Huntington.

Patient Bill of Rights
Advanced Directive Policy
Ownership Disclosure

_____
Signature

_____
Print Name

_____
Date

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THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION, PLEASE REVIEW IT CAREFULLY

The privacy of your medical information is important to us. You may be aware that U.S. government regulators established privacy rule ("HIPAA") governing protected health information. This notice tells you about how it may be used, and about certain rights that you have.

USE AND DISCLOSURE OF PROTECED INFORMATION:

Federal law provides that we may use your medical information (protected health information) for treatment of you, without further specific notice to you, or written authorization by you. Such as, "if we refer you to a specialist, we may provide laboratory or test data to that specialist (subject to more stringent New York laws, such as restriction on disclosure information concerning HIV/AIDS").

Federal law provides that we may use your medical information to obtain payment for our services without further specific notice to you, or written authorization by you, such as, "under your health plan, we are required to provide them with a diagnosis code for your visit and a description of the services rendered."

Federal laws provides that we may use your medical information for health care operations without further specific notice to you, or written authorization by you, such as, our accountants may see your name, dates of treatment and procedure codes during audits of our books. As a possible second example: we may use your information for financial services, quality assurance, risk deduction and claim management purposes without our medical professional liability insurer.

We may use or disclose your medical information, without further notice to you, or specific authorization by you, where:

1. Required by law;
2. Required for public health purposes;
3. Required by law to report child abuse;
4. Where required by a health oversight agency for oversight activities authorized by law, such as the Department of Health, Office of Professional Discipline or Office of Professional Medical Conduct;
5. Required by law in judicial or administrative proceedings;
6. Required for law enforcement purposes by a law enforcement official;
7. Required by a coroner or medical examiner;
8. Permitted by law to a funeral director;
9. Permitted by law for organ donation purposes;
10. Permitted by law to avert a serious threat to health or safety;
11. Permitted by law and required by military authorities if you are a member of the armed forces of the United States;

New York State law provides additional protection for information regarding HIV/AIDS. We will continue to follow New York State law with respect to such information.

We may contact you by mail or phone, at your residence, to remind you of appointments or to provide information about treatment alternatives. Unless you instruct us otherwise, we may leave you a message for you on any answering device or with any person who answers the phone at your residence.

You can make reasonable requests, in writing, for us to use alternative methods of communicating with you in a confidential manner.

Other uses or disclosures of your medical information will be made only with your written authorization. You have the right to revoke any written authorization that you give.

RIGHTS YOU HAVE:

You have the right to request restrictions on certain uses or disclosures described above. Except as stated below, we are not required to agree to such restrictions.

You have the right to inspect and obtain copies of your medical information (a reasonable fee will be charged).

You have the right to request amendments to your medical information. Such requests must be in writing and must state the reason for requested amendment. We will notify you as to whether we agree or disagree with the requested amendment. If we disagree with any requested amendment, we will further notify you of your rights.

You have the right to request an accounting of any disclosures we make of your medical information, except for disclosures we make to you, or to carry out treatment, payment or health care operation, or as requested by your written authorization, or as permitted or required under 45 CFR & 164.50, or for emergency or notification purposes, or for national security or intelligence purposes as permitted by law, or to correctional facilities or law enforcement officials as permitted by law (or for research or public health purposes after being de-identified or limited to remove personally identifiable information) or disclosures made before April 14, 2003.

OBLIGATIONS WE HAVE:

We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices. We are required to abide by the terms of this notice as long as it is currently in effect.

We reserve the right to revise this notice, and to make a new notice effective for all protected health information we maintain. Any revised notice will be posted in our facility, and copies will be available there.

If you want to complain about violations of your privacy rights, you have the right to file a complaint with the Secretary of the Department of Health and Human Services of the United States. You may also file a complaint with us. Complaints should be directed to Digestive Health Center of Huntington, 195 East Main Street, Huntington, NY 11743.

No retaliatory action will be taken against you for any complaint you make.

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RECEIPT OF HIPAA PRIVACY NOTICE

I make the following special request for confidential communications:

_____
_____
_____
_____
_____

Please initial here _____ I authorize the physicians and/or staff to leave messages on my answering machine or voice mail.

Or

Please initial here _____ I request **NOT** to receive messages.

I have received a paper copy of this notice.

_____
Signature

_____
Print Name

_____
Date

Revised 12/2021

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Dear Patient,

North Shore-LIJ Anesthesiology, P.C. is the provider of anesthesia services at Digestive Health Center of Huntington.

To ensure seamless coverage for your procedure, we participate with a broad range of health insurances ("Health Plan"). You can visit https://www.northwell.edu/AnesthesiaPC for an up-to-date listing of the plans in which we participate with.

After your procedure, we will bill your insurance company. You will be responsible for any copayment, coinsurance, or deductible your Health Plan deems as the patient's responsibility.

You may request an estimate of the cost associated with your procedure's anesthesia services by calling 914-666-8866.

Thank you,
North Shore-LIJ Anesthesiology, P.C.

I agree to pay for any copayment, coinsurance, deductible, or other patient responsibility amount. All claim checks received by the patient from their Health Plan must be sent to North Shore-LIJ Anesthesiology, P.C. within 10 days of receipt to avoid collections.

Patient Signature _____

Print Name _____

Date _____