History & Physical

Patients Name:_________________________________ Date: _______________

Date of Birth: _______________ Primary Care Physician: _________________________________

Chief Complaint:

☐ None ☐ Abdominal Pain ☐ Acid Reflux ☐ Belching ☐ Black Tarry Stool ☐ Bloating
☐ Change in Bowel Habits ☐ Constipation ☐ Diarrhea ☐ Difficulty Swallowing ☐ Flatulence ☐ GERD
☐ Heartburn ☐ Hemorrhoids ☐ Indigestion ☐ Milk/Dairy Intolerance ☐ Mucus in Stool ☐ Nausea
☐ Pain with Bowel Movement ☐ Rectal Bleeding ☐ Rectal Urgency ☐ Soiling Stool ☐ Vomiting
☐ Other (Please Explain)

____
____
____
____

Allergies: ☐ Patient has no known allergies

Please write reaction and circle severity for each Allergy: A= Acute M= Mild S= Severe

☐ Aspirin - Reaction: _______________ A M S ☐ Codeine - Reaction: _______________ A M S
☐ IV Contrast or Iodine - Reaction: ______________ A M S ☐ Penicillin - Reaction: ______________ A M S
☐ Sulfa Drugs - Reaction: _______________ A M S ☐ Propofol - Reaction: ______________ A M S
☐ Latex - Reaction: _______________ A M S ☐ Other: _________________________________

Current Medications (please include the strength and dose):

____
____
____
____
____
____
____

Past or Present Medical Conditions: Please specify PAST or PRESENT conditions

☐ None

Gastrointestinal And Liver
- ☐ Barrett's Esophagus ☐ Cirrhosis of liver ☐ Colon Cancer ☐ Colon Polyps
- ☐ Crohn's Disease ☐ Diverticulitis ☐ Diverticulosis ☐ Esophageal Varices
- ☐ Elevated Liver Enzymes ☐ Fatty Liver ☐ Gastric Varices ☐ GERD (reflux/heartburn)
- ☐ Hepatic encephalopathy ☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C
- ☐ Irritable Bowel Syndrome ☐ Liver Transplant ☐ Pancreatitis
- ☐ Stomach or Duodenal Ulcer ☐ Ulcerative Colitis ☐ Other: ________________________

Cardiovascular
- ☐ Abdominal aortic aneurysm ☐ Atrial Fibrillation ☐ Cardiac Vavular disease
- ☐ Congestive Heart Failure ☐ Coronary Artery Disease without heart attack
- ☐ Deep vein thrombosis ☐ Heart attack ☐ Heart murmur ☐ High Cholesterol
- ☐ Hypertension ☐ Stroke ☐ Transient ischemic attack ☐ Other: _____________

Other Conditions
- ☐ Alcoholism ☐ Anxiety ☐ Alzheimer ☐ Anemia ☐ Asthma ☐ B12 Deficiency
- ☐ Breast cancer ☐ Chronic Pain Syndrome ☐ Chronic Anticoagulation ☐ COPD
- ☐ Degenerative joint disease ☐ Diabetes ☐ Dialysis ☐ Depression ☐ Fibromyalgia
- ☐ Glaucoma ☐ Gout ☐ HIV/AIDS ☐ Home Oxygen ☐ Hyperthyroidism
- ☐ Hypothyroidism ☐ Iron Deficiency ☐ Kidney Stones ☐ Kidney Disease
- ☐ Kidney Transplant ☐ Lymphoma ☐ Osteoporosis ☐ Parkinson's disease
- ☐ Pneumonia ☐ Prostate cancer ☐ Rheumatoid arthritis ☐ Skin Cancer
- ☐ Other: ____

Diagnostic studies/Tests:

☐ None

Gastrointestinal
- ☐ Colonoscopy- When: ____
- ☐ EGD (Upper Endoscopy) - When: ____
- ☐ ERCP- When: ____
- ☐ Capsule endoscopy- When: ____
- ☐ Flexible Sigmoidoscopy- When: ____

Patients Name: ____ DOB: ________________

Previous Surgery/Procedures:

☐None ____

Gastrointestinal

☐ Appendectomy When: ___________
☐ Billroth When: ___________
☐ Cholecystectomy (Gall bladder removed) When: ___________
☐ Colon Resection When: ___________
☐Gastric Banding When: ___________
☐ Gastric Bypass When: ___________
☐Hemorrhoid Surgery When: ___________
☐ Hiatal Hernia surgery/anti-reflux surgery When: ___________
☐ Lysis of adhesions When: ___________
☐ Partial Gastrectomy When: ___________
☐ Small bowel resection When: ___________
☐ Other: ___________________ When: ___________

____

Cardiovascular

☐ Abdominal aortic aneurysm When: ___________
☐ Aortic Valve Replacement When: ___________
☐ Cardiac Pacemaker When: ___________
☐ Coronary artery bypass graft When: ___________
☐ Carotid endarterectomy When: ___________
☐ Cardiac stent When: ___________
☐ Cardiac valve replacement When: ___________
☐ Mitral valve replacement When: ___________
☐ Cardiac defibrillator When: ___________
☐ Peripheral vascular surgery When: ___________
☐ Other: _______________________ When:_____________

____

Other

☐ Breast cancer surgery When: ___________
☐ C-Section When: ___________
☐ Groin hernia When: ___________
☐ Hysterectomy When: ___________
☐ Carotid endarterectomy When: ___________
☐ Prostatectomy When: ___________
☐ Thyroid When: ___________
☐ Tonsillectomy When: ___________
☐ Total hip replacement When: ___________
☐ Total knee replacement When: ___________
☐ Tubal Ligation When: ___________
☐ Other: ______________________ When: ______________

Family Medical History:

☐ No Knowledge of family History____

☐ No family history of: ☐ Colon Cancer ☐ Colon Polyps ☐ Esophageal Cancer ☐ Esophageal Polyps

Diagnoses	Grandmother	Grandfather	Mother	Father	Sister	Brother
Colon Polyps	☐	☐	☐	☐	☐	☐
Colon Cancer	☐	☐	☐	☐	☐	☐
Esophageal Polyps	☐	☐	☐	☐	☐	☐
Esophageal Cancer	☐	☐	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Heart attack	☐	☐	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐
Liver disease	☐	☐	☐	☐	☐	☐
Other Cancer	☐	☐	☐	☐	☐	☐

Type: ________________

Social history:

Alcohol

☐ None Quantity Frequency

☐ Beer ____

☐ Wine ____

☐ Liquor ____

☐ Other ____

Tobacco

☐ None ☐ Current smoker; how long: __________ How many packs daily: ________

☐ Former smoker; when stopped: ___________

PATIENT REGISTRATION AND CONSENT FORM

*It is important that you fill this form out completely, even if we may already have this information.
If you should need assistance in completing this form, please ask a staff member for help.

PATIENT INFORMATION

Last Name: __________________________ **First Name:** ___________________________ **Middle Initial:** _____ **Suffix:** _____

Mailing Address: ______________________________ **Apt#** ________ **City:** _______________ **State:** ______ **Zip:** ________

Date Of Birth: ___________ **Sex:** ☐ Male ☐ Female **Social Security #** ________________ **Marital Status:** _________

Home Phone: ( )______________ **Cellphone:** ( )______________ **Work Phone:** ( )______________**EXT:** ______

ETHNICITY/RACE: ☐ American Indian or Alaska Native ☐ Hispanic or Latino ☐ Asian ☐ Black or African American
☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Other

Preferred Language: ________________ **Email Address:** __________________________ **Employer:** _________________

Primary Care Doctor: ______________________ **Pharmacy:** _________________ **Pharmacy Location:** _________________

Prescription Coverage Company: ________________________ (Who takes care of your prescriptions. Example: CVS Caremark, ProAct)

HIPAA COMMUNICATION PREFERENCE

What is your primary phone contact? ☐ Home Phone ☐ Cellphone ☐ Work Phone
May we leave a voicemail? ☐ Yes ☐ No
May we communicate with anyone on your behalf? ☐ Yes, _______________________ (_________________) ☐ NO
(who) (relationship)

EMERGENCY CONTACT

Last Name: __________________________ **First Name:** ___________________________

Home Phone: ( )______________ **Cellphone:** ( )______________ **Work Phone:** ( )______________**EXT:** ______

Relationship to Patient: ☐ Spouse ☐Parent/Guardian ☐ Child ☐ Friend ☐ Other

INSURANCE INFORMATION

Primary Insurance: ________________________ **Subscriber ID:** _______________________ **Group #**________________
Effective Date: _______________ **Copay Amount For Specialist:** ______________

Secondary Insurance: ______________________ **Subscriber ID:** _______________________ **Group #**________________
Effective Date: _______________ **Copay Amount For Specialist:** ______________

GUARANTOR INFORMATION (POLICY HOLDER FOR INSURANCE)

☐ **SELF (Patient)**

If other than patient, please fill out information below.

Last Name: __________________________ **First Name:** ___________________________ **Date Of Birth:** _____________

Mailing Address: ______________________________ **Apt#** ________ **City:** _______________ **State:** ______ **Zip:** ________

Sex: ☐ Male ☐ Female **Social Security #** __________________ **Relationship to Patient:** _________________________

Authorization to release information

I hereby authorize Ulster Gastroenterology, PLLC, Dr. Reham El-Shaer, to release any medical or incidental information that may be necessary for other medical care or in processing application for financial benefit. This office is not responsible for any dissemination or disclosure of your confidential medical information once we provide such information, at your request, to your health insurer or employer.

Signature ____ Date _____________________

Assignment of Insurance Benefits

I hereby authorize direct payment of medical/surgical payment to Ulster Gastroenterology, PLLC, Dr. Reham El-Shaer for services rendered by her in person or under her supervision. I understand that I may be required to pay a deductible, co-pay, co-insurance, or any balance not covered by my insurance plan. In the event that my insurance does not fully pay for services and/or materials rendered to me, I agree to be responsible for payment of all balances on my or my dependent's behalf.

Signature ____ Date _____________________

Medicare / Medicaid

Name for beneficiary ______________________________________ ID number _______________________

I request that payment of authorized Medicare or Medicaid benefits be made to either me or Ulster Gastroenterology, PLLC, Dr. Reham El-Shaer, for any services furnished to me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information to determine those benefits payable for related services.

Signature ____ Date _____________________

Acknowledgement of Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information about you. We are required by law to maintain the privacy of your health information and make every effort to inform you of your rights. By signing below, I acknowledge that I have reviewed or had explained to me the Notice of Privacy Practices and agree to continue my care with Ulster Gastroenterology, PLLC under said terms.

Signature ____ Date _____________________

FINANCIAL POLICY

We are committed to providing you with the best possible care and your understanding of our financial policy is important to our professional relationship. Please ask if you have any questions regarding our fees and policies.

As a courtesy our office will bill your insurance for the services you will receive. We cannot bill your insurance company unless you give us correct insurance information. Patients must inform us of changes in information or insurance plans prior to seeing the physician. It is your responsibility to know and advise us of your plan's requirements in advance, each and every time we provide a service. If your plan requires a referral from your PCP, it is your responsibility to present the referral prior to the service. Please be advised that if we have not been informed of your program's requirements and if we provide a physician or surgical service, you may be responsible for payment if Insurance denies the claim. Please understand that your bill is ultimately your responsibility whether your Insurance Company pays or not. Your Insurance policy is a contract between you and your Insurance Company. We are not a party to that contract.

Participating Plans: Patients must pay all Co-Pays at the time of service. If you have a high deductible you will be required to pay a fee of $500 upfront for your procedure, if your insurance pays more than anticipated all credit will be refunded if applicable. Your Insurance Company will be billed for your services. Any remaining balances such as your deductible or co-insurance if applicable will be your responsibility.

Non Participating/Out of Network Services or SELF PAY: Payment in FULL is expected at time of service unless arrangements have been made in advance with the billing staff. All claims will be submitted to your Insurance Company as a courtesy.
**We DO NOT accept United Healthcare (excluding AARP), NYSHIP (The Empire Plan) through United Healthcare, Emblem, Magnacare (excluding KINGSTON TRUST) and straight Medicaid.

Medicare: You are responsible for your annual Medicare deductible and co-insurance of 20%.

Cancellations: We have experienced a significant increase in the demand for medical procedures and services. We have also seen an increased cost associated with these services. We are committed to providing you with the best possible care for each patient's time in our office.
Unfortunately, we have also seen in increase in the number of patients failing to come to their appointments or canceling late. This prevents us from having the ability to fill that appointment and meet other patient's medical needs.
If you are scheduled for an office appointment, we must receive a notice of cancellation at least 24 hours in advance (1 business day). If you are scheduled for a procedure, we must receive a notice of cancellation at least 48 hours in advance (2 business days). Due to our office being closed on Friday, Saturday and Sunday a notice of cancellation for a Monday appointment or procedure must be received on the Thursday before.

Late Cancellations and No Shows will result in the following fees:
$50.00 for OFFICE VISITS
$200.00 for PROCEDURES
The charge for a Late Cancellation/No Show will be billed directly to you. Insurance Companies will NOT cover this fee.

Ancillary Services: Please be aware that there may be a charge involved for ancillary services such as multiple telephone calls, extended telephone conversations, telephone calls made after normal business hours to the Clinician on call, completing disability forms and/or forms related to your care, and drafting letters on your behalf.

- The telephone consultation fee will depend on the duration of the call(s), costing up to $175.

Patient Balances:

Any NO SHOW/LATE CANCELATION FEE(s) that are owed MUST be paid FIRST IN FULL before ANY future appointments are made.

Please note, having an outstanding balance may affect future appointments.

If a balance is owed, you must pay a minimum of 30% of the total balance per payment.

Balances paid within 90 days will not have an interest charge.

If an account balance is unpaid for over 90 days, your account will be placed into collections. Once your account is in collections, you will no longer be able to make payments through our office. You will be contacted by an Attorney that represents Ulster Gastroenterology, to seek payment on the account in debt. This debt will have a 7% interest charge per month, and you will also be responsible for any Attorney fees accompanied with the process of collecting payments.

Any returned checks will have a $30 fee added to the balance.

Thank you for taking time to review our Financial Policy. We appreciate your understanding of this policy and thank you for your cooperation.

I have read the Financial Policy in full and agree to all terms and conditions.

____

Printed Name of Patient

____________________________________ __________________

Signature of Patient/Guardian Date Signed

Notice of Privacy Practices

How your medical information will be used and disclosed:
The Practice will use your medical information as part of rendering patient care. Your medical information may be used for treatment, payment, or health care operations. As to treatment, we may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, and other personnel of the Practice. We may also disclose medical information about you to people outside the Practice who may be involved in your medical care. As to payment, we may use and disclosed medical information about you so that the treatment and services you receive at the Practice may be billed to and payment may be collected from you, an insurance company, or third party. These uses and disclosures are necessary to run the facilities of the Practice, and to make sure that all our patients receive quality care.

The Practice may also use and/or disclose your medical information in accordance with federal and state laws for the following purposes:

To contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

When required by the U.S. Department of Health and Human Services as part of an investigation or determination of compliance by the Practice with relevant laws.

Unless you object, the Practice may disclose to family members, or other relatives, or close personal friends the medical information directly relevant to such person's involvement with your care. The Practice may also give relevant information to an individual who helps pay for your care.

For public health activities, including the reporting of disease, injury, vital events, and the conduct of public health surveillance, investigation and /or intervention, or to a health oversight agency for oversight activities authorized by law, including audits, investigations, inspections, licensure or disciplinary actions, and administrative and/or legal proceedings.

If you are involved in a lawsuit, claim, potential claim, or dispute, we may disclose medical information about you to attorneys, investigators, insurance companies, and related entities representing the interests of or insuring the doctors and/or other personnel affiliated with the Practice. We may also disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

For federal, state, or local law enforcement purposes, or other specialized governmental functions, as follows: 1) in response to a court order, subpoena, warrant, summons, or similar process; 2) to identify or locate a suspect, fugitive, material witness, or missing person; 3) about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement; 4) about a death we believe may be the result of criminal conduct; 5) about criminal conduct at this facility; and 6) in emergency circumstances, to report a crime, the location of the crime or victims, or the identity, description, or location of the person who committed the crime.

To a coroner, medical examiner, or funeral director.

To an organ donation and procurement organization if you are an organ donor.

To prevent or lessen a serious threat to the health or safety of another person or the public. Any disclosure, however, would only be to someone able to prevent the threat.

As authorized by laws relating to workers' compensation or similar programs.

As required by domestic or foreign military command authorities, if you are a member of the armed forces of the United States or a foreign country.

To obtain payment for health care services that we provide you. This may include disclosures to your health insurance plan, and disclosures to third parties with respect to payment to such party.

The Practice will not use or disclose your medical information for any other purpose without your written authorization. Once given, you may revoke your authorization in writing at any time. However, we are unable to take back any disclosures we have already made by your permission. We are required to retain our records of health care services we provide you.

Your Rights Regarding Your Medical Information:
You have the following right regarding medical information we maintain about you:

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Practice. You must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support a request. In addition, we may deny your request if you ask us to amend information that:

Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;

Is not part of the medical information kept by or for the Practice; or

Is not part of the information which you would be permitted to inspect and copy.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone else who is involved in your care or payment for your care, like a family member or friend. We are not required to agree with your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment, or as otherwise permitted by law. In your request you must tell us 1) what information you want to limit; 2) whether you want to limit our use, disclosure, or both; and 3) to who you want the limits to apply.

Right to Request Alternative Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. We will not ask you the reason for the request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

____

Printed Name of Patient

____ ________________

Signature of Patient/Guardian **Date Signed**

Patient Rights

Patients have the right to receive treatment without discrimination as to race, color, religion, sex, national origin, disability, sexual orientation, source of payment, or age.

Patients have the right to be treated with respect, consideration and dignity. They have a right to privacy.

Patients have the right to know the names, positions and functions of any staff involved in their care and refuse their treatment, examination or observation.

Patients have the right to receive complete information about their diagnosis, treatment and prognosis.

Patients are involved in all aspects of care. Informed consent, following a discussion of risks, benefits and alternative, will be obtained.

Patients are given the opportunity to participate in decisions involving their health care, except when such participation is contraindicated.

Patients have the right to refuse treatment to the extent permitted by law and to be fully informed of the medical consequences of his/her action.

Patients have the right to view their medical records and ask questions unless restricted by law.

Patient records and disclosures are treated confidentially, and except when required by law, patients are given the opportunity to approve or refuse their release.

Patients have the right to fees for services and to receive information concerning the bill for services and payment policies.

Patients have the right to request information regarding advanced directives

Your Responsibilities as a Patient

In addition to your rights as a patient, you also have responsibility to:

Provide, to the best of your knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications and other matters relating to your health.

To report unexpected changes in your condition to the responsible practitioner.

Make it known whether you clearly understand a contemplated course of action and what is expected of you.

Follow the treatment plan recommended by the practitioner primarily responsible for your care. This may include following the instructions of nurses and allied health personnel as they carry out the coordinated plan of care and implement the responsible practitioner's orders and as they enforce the applicable rules and regulations.

Keep appointments, and when you are unable to do so for any reason, notify the office.

Be accountable for your actions if you refuse treatment or do not follow the practitioner's instructions.

Assure that the financial obligations of your health care are fulfilled as promptly as possible.

Follow the rules and regulations affecting patient care and conduct.

Be considerate of the rights of other patients and staff.

Respect the property of other persons and of the facility.

Provide a responsible adult for transportation after procedures if you receive sedation.

Provide any Advance Directive information.

____

Printed Name of Patient

____ ____________________

Signature of Patient/Guardian **Date Signed**

UPCOMING APPOINTMENTS

We are trying to provide the best quality of care to every patient as much as we can, that's why we request that patients understand the importance of keeping their appointments, or giving the office enough time to re-arrange the schedule if not planning to come in, so that we can help other patients as well.

When we have to leave a message, we ask that you verbally confirm your appointment no less than 24 hours for office visits, and no less than 48 hours if you are coming in for a procedure. If we do not receive confirmation from you

within this time frame, your blocked time will be moved to the last appointment of that day. If you fail to show up for your appointment, you will be responsible for No Show, or Late Cancel Fees.

Thank-you

Print Name ________________________

Sign Name ________________________

Date __________________

Consent to Receive Automated Phone reminders

Text reminders and/or Email reminders

By signing below, I authorize Ulster Gastroenterology to contact me by Automated Phone reminders, Text reminders and/or Email reminders.

Cell phone number: _______________________

Email: ______________________________

Patient Name (print): __________________________

Signature: ___________________________

DOB: ____________________

Today's Date: _____________________

Ulster Gastroenterology, PLLC
Reham El-Shaer, MD
Rhonda Darmstadt, NP
301 Hurley Ave., Kingston, NY 12401
PH: 845-309-7597 Fax: 845-802-0822

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize the use or disclosure of information from the medical records of:

Patient name: ________________________________ Date of Birth: _____________________

I authorize the following individuals or organizations to disclose the above named individual's health information:

___Primary Care Doctors ___Labs ___Hospital/ER Records ___Radiology ___Specialists

This information may be disclosed to and used by the following individual or organization:

Ulster Gastroenterology, Dr. Reham El-Shaer, MD / Rhonda Darmstadt NP
301 Hurley Ave, Kingston, NY 12401.

Release good until revoked by patient.

For the purpose of: Continuation of care

Please release the following:

___office note(s) ___Biopsy report(s) ___Imaging report(s) ___ Bloodwork/Stool test(s)

I understand that the information released is for the specific purpose(s) stated above. Any other use of this information without the written consent of the patient is prohibited. I understand that authorizing the disclosure of this health information is voluntary. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for the unauthorized redisclosure and the information may not be protected by federal confidentially rules.

____
Signature of patient

____
Printed Name of patient

____
Date