PLEASE NOTE THE FOLLOWING

- Please fill out the enclosed forms and bring them with you at your appointment. Please do not mail them ahead of time.

- If you are on any medications, please bring the actual medication bottles with you on your first visit with the doctor. If this is not your first visit, please bring a written list of your medications.

- Please be prepared to pay your co-pay at the time of service. Co-pays must be paid at the time of service or your appointment will be rescheduled.

- If you have had any recent blood tests, ultrasounds, CT scans, or x-rays, please have those reports with you or faxed over to us before your appointment. (fax 860-674-8984)

INSURANCE REFERRALS

Patients are responsible for obtaining any referrals from their Primary Care doctor as required by their insurance company. Failure to obtain a valid referral prior to your appointment may result in you being financially responsible for the visit at the time of service. Except in an emergency situation, the physician/office has the right to reschedule your appointment until a valid referral can be obtained.

Office ____________

Physician ____________

PATIENT REGISTRATION SHEET

PATIENT INFORMATION

SSN# ____________

Last Name: ____________ First Name: ____________ MI: ______ Suffix: ______

Address: ____________

City ____________ State: ____________ Zip: ____________

Home Phone: ____________ Work: ____________ Cell: ____________

Which telephone number is best to reach you? Please check ☐ Home ☐ Work ☐ Cell

Sex (M/F): ______ Date of Birth: ____________ Employer : ____________

Can we contact you via email? ☐ Yes ☐ No Email Address: ____________

PCP: ____________ Referring Dr: ____________

Marital Status (S/M/W/D): ______ Race: ____________ Patient Prefers Not to Answer______

Emergency Contact: ____________ Relationship: ____________

Emergency Home Phone: ____________ Work: ____________ Cell: ____________

INSURANCE INFORMATION

Primary Insurance: ____________ Policy Holder: ____________

Policy Holder DOB: ____________ Patient Relationship to Policy Holder: ____________

Policy ID #: ____________ Policy Group #____________

CLAIM ADDRESS:____________

Secondary Insurance: ____________ Policy Holder: ____________

Policy Holder DOB: ____________ Patient Relationship to Policy Holder: ____________

Policy ID #: ____________ Policy Group#: ____________

CLAIM ADDRESS:____________

LOCAL PHARMACY NAME: ____________ **PHONE NUMBER**:____________

ASSIGNMENT OF BENEFITS STATEMENT

I herby authorize direct payment of medical/surgical benefits to PRIME *Healthcare, PC* for services rendered by our providers. I understand that I am financially responsible for any balance not covered by my insurance. I certify that the information given by me in applying for payment is correct. I hereby authorize PRIME *Healthcare, PC*, its agents and representatives, to access information regarding my person, whereabouts and medical history and to release all necessary information to my insurance company regarding my medical history, examinations, and treatment for the purposes of processing my insurance coverage. A photocopy of my signature is as valid as the original.

____________ Date: ____________
Signature of Beneficiary/Guarantor

Do you want to discuss a living will or advanced directives? ______ Yes ______ No ______ I have a living will.

All Patients: please complete pages 1,2 & 3 and SIGN at end of page 3 **Prime HealthCare GI History**

Last Name	First Name	Date of Birth	Today's Date

Circle the number of years of formal education you have completed

8	9	10	11	12	13	14	15	16	>16

Who suggested our office to you?

A physician referred me	Who?
A friend referred me	Who?
Other	Explain
Who is your primary care MD?	

Please state in one or two sentences the major reason for your visit.

Please list all previous operations with approximate dates. Circle None if appropriate.

1) None	6)
2)	7)
3)	8)
4)	9)
5)	10)

Please check the boxes next to all illnesses you have or have had.

- ❒ Atrial Fibrillation
- ❒ Angina Pectoris
- ❒ Artificial Heart Valve
- ❒ High Blood Pressure
- ❒ Pacemaker
- ❒ High Cholesterol
- ❒ Heart Attack
- ❒ Bleeding Disorder
- ❒ Emphysema
- ❒ Asthma
- ❒ Tuberculosis
- ❒ HIV/AIDS
- ❒ Diabetes
- ❒ Osteoporosis
- ❒ Thyroid Disorder
- ❒ Colon Polyps
- ❒ Irritable Bowel
- ❒ Ulcers
- ❒ Crohn's Disease
- ❒ Ulcerative Colitis
- ❒ Liver Cirrhosis
- ❒ Hepatitis
- ❒ Gallstones
- ❒ Lactose Intolerance
- ❒ Pancreatitis
- ❒ Diverticulosis
- ❒ Sprue
- ❒ Esophagitis
- ❒ Anemia
- ❒ Latex Allergy
- ❒ Cancer: Colon
- ❒ Cancer: Esophagus
- ❒ Cancer: Stomach
- ❒ Cancer: Pancreas
- ❒ Cancer: Prostate
- ❒ Cancer: Breast
- ❒ Excessive Alcohol Use
- ❒ Drug Abuse
- ❒ Depression
- ❒ Anxiety
- ❒ Suicide Attempt
- ❒ Stroke
- ❒ Migraine Headache
- ❒ Endometriosis
- ❒ Arthritis

List any other illnesses. Circle None if appropriate.

1) None	4)
2)	5)
3)	6)

I have reviewed the Prime HealthCare History

Physician Signature: ______________________________ ***Date:*** ____ / ____ / ____

Please list any family members who have had any of the following problems.

Disease	Relation to you	Disease	Relation to you
Cancer: Colon		Colon Polyps	
Cancer: Esophagus		Crohn's Disease	
Cancer: Stomach		Ulcerative Colitis	
Cancer: Breast		Lactose Intolerance	
Sprue		Bleeding Problems	
Diabetes		Heart Disease	
Anemia		Alcohol Abuse	
Gall Bladder Stones		Hepatitis	
Liver Disease (cirrhosis)		Other	

List all your medications (including aspirin & laxatives). Circle None if appropriate

Name of Drug	Dose? (e.g. mg.)	How Often?
None		
1)		
2)		
3)		
4)		
5)		
6)		
7)		
8)		
9)		

List all your medication allergies. If none are known, circle None.

None	3)	6)
1)	4)	7)
2)	5)	8)

Please circle the term that best describes your current employment status & describe.

Employed	Describe:
Retired	Previous job:
Unemployed	Previous job:
Student	Where?

Describe your use of the following: Circle None if appropriate.

Tobacco Use	None	____ Packs per day for ____ years	Stopped ____ years ago
Alcohol Use	None	Amount:	Stopped ____ years ago
Illegal Drug Use	None	Type & Amount:	Stopped ____ years ago
Coffee/tea	None	8 oz. cups per day:	

Please circle your answer:

Have you been vaccinated against hepatitis B?	Yes - No - Don't Know
Do you wish to be screened for colon cancer?	Yes - No - Don't Know

Last Name	First Name	Date of Birth	Today's Date

Please indicate whether you experience these symptoms. Circle yes or no.

Symptoms			Physician Comment
Lack of energy	Yes	No	Constitutional
Trouble sleeping	Yes	No	
Weight Loss (10 lbs in 1 yr)	Yes	No	
Weight gain (10 lbs in 1 yr)	Yes	No	
Fevers	Yes	No	
Hard or infrequent bowel movements	Yes	No	GI
Loose or frequent bowel movements	Yes	No	
Blood in bowel movements	Yes	No	
Vomit blood	Yes	No	
Heartburn/Indigestion	Yes	No	
Food sticks when swallowing	Yes	No	
Painful swallowing	Yes	No	
Yellow jaundice	Yes	No	
Chest pain	Yes	No	Cardiovascular
Irregular heartbeat	Yes	No	
Palpitations	Yes	No	
Swollen legs	Yes	No	
Fainting	Yes	No	
Shortness of breath	Yes	No	Respiratory
Wheezing	Yes	No	
Coughing up blood	Yes	No	
Asthma	Yes	No	
Frequent urination	Yes	No	GU
Blood in urine	Yes	No	
Difficulty urinating	Yes	No	
Could you be pregnant	Yes	No	
Painful menses	Yes	No	
Joint swelling	Yes	No	Musculoskeletal
Joint redness	Yes	No	
Gout	Yes	No	
Muscle aches	Yes	No	
Breast lump	Yes	No	Breast/Skin
Unusual or new rash	Yes	No	
Paralysis	Yes	No	Neuro
Stroke	Yes	No	
Seizures	Yes	No	
Loss of memory	Yes	No	
Depression	Yes	No	Psychological
Do you feel safe in current relationship	Yes	No	
Anxiety	Yes	No	
Diabetes	Yes	No	Endocrine
Excessive thirst	Yes	No	
Bleeding	Yes	No	Hemo
Easy bruising	Yes	No	
Allergy to shellfish	Yes	No	Allergy
Allergy to X-ray dye	Yes	No	

Patient's Signature ______________________________ Date ____________________

PRIME HEALTHCARE, PC
Gastroenterology/Internal Medicine

HIPAA PATIENT CALLING INFORMATION

Name:____

Date of Birth:______________________

With whom do you allow us to share your personal medical information?

Name____________________________ Relationship_____________________

Name____________________________ Relationship_____________________

Name____________________________ Relationship_____________________

How may we contact you?

Home Phone:__________________________
_____ DO NOT leave a message
_____ Leave brief message, return#
_____ May leave a detailed message

Work Phone:__________________________
_____ DO NOT leave a message
_____ Leave brief message, return #
_____ May leave a detailed message

Cell Phone:____________________________
_____ DO NOT leave a message
_____ Leave brief message, return#
_____ May leave a detailed message

**I understand that it is my responsibility to notify the office of any changes in my calling information.

SIGNATURE____________________________________ **DATE**______________

PRIME HEALTHCARE

Gastroenterology
Ronald P. Josephson, M.D.
Brian Van Linda, M.D., MBA
Anthony Zaldonis, M.D.
Carol A. Petruff, M.D.
Golam R. Gazi, M.D., F.R.C.P.,(C)
Janice M. Whedon, APRN
Lani F. Ralston, APRN

Internal Medicine
Sybil L. Sandoval, M.D.
Wayne Chen, M.D.

PAYMENT POLICY

Name of Patient:______________________________ D.O.B.____________________

1. **Insured Patients.** We do participate with many insurance plans and will gladly submit to them your information. Co-payments are paid at the time of the service. If you do not have your co-pay we will exercise our option to reschedule your visit. The co-pay is part of your contract with your insurer. You are responsible for your co-pay at the time of service. To not collect the co-pay is fraud on our behalf. Deductibles will be billed to you after notification from your insurer to this office. You must present a valid insurance card at the time of service. Knowing your insurance is your responsibility. You need to take the responsibility to contact your insurance company for the particulars of your coverage.
2. **Non-Insured Patients.** If you are not insured by a plan that we participate with or have no insurance coverage at all, payment is expected at the time of your visit. If you cannot make payment in full, a minimum payment of $50 is required prior to your seeing the doctor. This will not be billed out for later payment. You must pay prior to seeing the doctor. A procedure requires a $100 deposit. Both the $50/100 is a deposit and is not the full amount that you are responsible to pay. We will gladly work with you on a payment plan.
3. **Screening Colonoscopy.** A colonoscopy is considered diagnostic when the patient is experiencing a symptom that requires further examination. A screening colonoscopy is done when there is an absence of symptoms or problems or your family physician has determined that this be done because of age or family medical history. A screening colonoscopy may fall under the wellness/preventive benefits of your policy. If this is the case, some insurers are not covering this procedure. While we may obtain the pre-cert for this procedure it will only be covered if your policy includes it. This is very important that you personally look over your policy and that you call your insurer to make sure they will pay for this screening.
4. **Payment Methods**. We accept Visa, MasterCard, Discover, Checks, or cash.
5. **Non-payment.** If you account is 75 days past due, you will receive a final letter stating that we exercise our option to collect moneys owed to us by turning the account over to Transworld Systems, Inc. While we hesitate to do this, we will pursue moneys owed to the practice. Also please be aware that if a balance remains unpaid, you may be discharged from the practice for failure to make an honest attempt at payment. If this does occur you will receive a certified letter indicating that you have 30 days to find other medical care.

******While our physicians are dedicated to your health care, you the patient must recognize that in order to continue serving you we must charge for services as they are delivered to you. It is your responsibility to pay for these services as they occur so that our physicians and staff may continue to serve you 24-7. Thank you. ********

I understand the payment policy in full and agree to the financial responsibility for myself/dependents for all Medical services rendered thereof:

______________________________ ____________________

Signature of patient responsible party Todays Date

Printed Name:______________________________

Relationship to Patient:______________________________

HARTFORD DIRECTIONS: 19 Woodland St. , Suite 43

FROM 84 WEST
- Take the Sigourney Street exit 47
- Turn right off the ramp onto Sigourney Street
- At next light, take a left onto Farmington Ave.
- At approximately the third light, you turn right onto Woodland St.
- We are on the left at 19 Woodland Street, Suite 43.
- Parking is in the back of the building.

FROM 84 EAST
- Take the left exit for Sisson Ave.
- Turn right off the ramp and continue to the end which is Farmington Ave.
- Take a right onto Farmington Ave.
- At the next light, take a left onto Woodland St.
- We are on the left a few buildings up, 19 Woodland St., suite 43. Parking is available in the back of the building.

AVON DIRECTIONS: 44 Dale Road

FROM 84 EAST
- Take exit 39, Route 4 Farmington
- At the light, continue straight on Route 4 going through Farmington about 4-5 miles.
- At the light where you see Farmingdale Condominiums/Apartments and Wood & Tap Restaurant, turn right onto Brickyard Road.
- Continue straight to the 1st stop sign. Brickyard road becomes West Avon Road at the first stop sign. (Route 167)
- You will go straight through the 5th traffic light. (You will then pass the Governor's horse stables on your right.)
- Go to the 2nd light after the stables which will be Dale Road on your right. We are the first driveway on the right. 44 DALE ROAD.

FROM 84 WEST
- Take the left exit (39) for Route 4 in Farmington
- Follow the above directions from 84 East after getting off the exit.

FROM ROUTE 44
- As you are coming down Route 44 over Avon Mountain from Bishops corner in Hartford, you will continue on RT 44 for 6.9 miles and come to Dale Road on your left at the light. Rite Aide Plaza will be on your left. Take that left and go to your 4th driveway on the left. This will be 44 Dale Road. The first brick building. We are on the 2nd floor.

TURN PAGE OVER FOR MORE OFFICE DIRECTIONS

DIRECTIONS TO OUR OFFICE

ENFIELD OFFICE: 146 Hazard Ave. Suite 202

Going 91 North or South

- Take exit 47E(Hazardville/Somers)
- This brings you onto Hazard Avenue
- You will pass Brookside Plaza on the right
- Our building(Johnson Memorial Building) is on the right

EAST HARTFORD: 893 MAIN ST. ; GATEWAY SQUARE;SUITE 202

Going 84 East

- Take Exit 53 Connecticut Boulevard exit
- Stay left off of exit
- Continue straight towards Main Street
- Take Walgreen Pharmacy/Gateway Square driveway on left side
- Our building is at the corner of Connecticut Boulevard and Main St.
- We are located in Suite 202 in the Gateway Square building

WETHERSFIELD: 350 Silas Deane Highway, Suite 102(Dr. Gazi's office)

Going 91 North or South

- Take Exit 28 (for routes 5 & 15:Silas Deane)
- You then go to the next exit which is 85
- Yield off exit going straight onto Silas Deane Highway.
- Go straight through 2 traffic lights. Right before the 3rd traffic light you will see a brick building and driveway on your left. This is our building.
- You can enter either at that driveway before the 3rd light or turn left at the 3rd traffic light onto Knott Street and our driveway is the first one on the left.
- Our office is on the corner of Silas Deane Highway and Knott Street.

Acknowledgement of Receipt of Notice of Privacy Practices

Prime HealthCare, P.C.

F.V. Gastroenterology Group

44 Dale Road, Avon, CT 06001

Privacy Officer (860) 263-0253 EXT 231

Name of Patient: ______________________________

☐ I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I may request a copy of any amended Notice of Privacy Practices at each appointment.

☐ I acknowledge and grant my authorization for publication of my personal, identifiable, and/or proprietary information through the AllscriptsTouchworks EMR (Electronic Medical Record) system for use and disclosure as described in paragraph B.3.b.on pages 4 to 5 of this medical practice's Notice of Privacy Practices. I also understand that use of the Allscripts Touchworks EMR system may result in my patient information being able to be accessed by healthcare providers other than my Prime HealthCare providers, however I understand and acknowledge this is limited to only those healthcare providers who are part of a sub group of the St. Francis Physician Hospital Organization (PHO) who also are using the Allscripts Touchworks EMR system. I further understand and acknowledge that such providers are also obligated to safeguard and protect my healthcare information in accordance with all HIPAA Privacy and Security regulations. I acknowledge and agree that my Prime HealthCare provider ('Group") will enter my protected health information ("PHI") in a database maintained by the Saint Francis Hospital and Medical Center (the "Hospital"). The PHI maintained in the database will be used by this Group for treatment, payment and health care operations purposes. The Group may also disclose my PHI maintained in the database to another provider (i) for treatment purposes, (ii) for payment purposes and (iii) for health care operations if I have or had a relationship with the other provider and only for the following reasons: (a) conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities; population-based activities relating to improving health or reducing health care costs protocol development, case management and care coordination, contacting of health care providers and patients with information about treatment alternatives; and related functions that do not include treatment; or (b) reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, health plan performance, conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers, training of non-health care professionals, accreditation, certification, licensing, or credentialing services; or (c) health care fraud and abuse detection or compliance. The Group may also disclose my PHI maintained in the database to the PHO as a Business Associate of the Group for health care operational purposes, including without limitation, quality and utilization review of health care services.

Signed: ____________________ Date: ____________________

Print Name: ____________________ Telephone: ____________________

If not signed by the patient, please indicate your relationship to the patient: ____________

For Office Use Only:

☐ Signed form received by: ____________________

☐ Acknowledgment refused:

Efforts to obtain: ______________ Reasons for refusal: ______________

Revised 02/09