Medication Profile

> KNOW YOUR MEDICATIONS <

NAME: _____ DATE: _____

ALLERGIES: _____

MEDICINE, HERBAL, VITAMIN, OR REMEDY	DOSAGE (mg) and how often	For what medical problem

PHARMACY NAME AND PHONE #:

Rajiv Bansal, M.D.
Avigayil Neuburger, PA-C

NEW PATIENT INTAKE FORM

Name:_____ Referring Physician:_____

Reason for visit: _____

_____

_____

Have you ever seen another gastroenterologist for this problem? ☐No ☐Yes If yes, who? _____

Have you been admitted to the hospital or presented to the ER recently? ☐ No ☐Yes If yes, where, why?

_____

Have you had recent imaging for this problem? ☐ Abdominal ultrasound ☐ ct scan ☐ MRI

GI REVIEW OF SYMPTOMS: *Are you currently experiencing any of the following symptoms?* ☐ Not applicable

Abdominal Pain: ☐ No ☐ Yes If yes, for how long?_____

Check all that apply: ☐ Intermittent (on and off) ☐ Dull Ache ☐Relieved by passing gas/bowel movement
☐ Constant ☐ Cramping ☐No relief with passing gas/ bowel movement
☐ Sharp ☐ Better with food ☐ Worse with food
☐ Burning ☐ No effect with food

Bloating/Gassiness ☐ No ☐ Yes If yes, for how long? _____

Heartburn ☐ No ☐ Yes If yes, for how long?_____

Food stuck in esophagus ☐ No ☐ Yes If yes, for how long?_____

☐ Liquids ☐ Solids ☐ Both ☐ Pills

Vomiting ☐ No ☐ Yes If yes, for how long?_____ ☐ Food ☐ Bile (green)

Diarrhea ☐ No ☐ Yes If yes, for how long?_____

☐ Recent Travel ☐ No ☐ Yes. If yes, where?_____

☐ Antibiotic in last 3 months? ☐ No ☐ Yes. If yes, what? _____

Constipation ☐ No ☐ Yes If yes, for how long?_____

☐ Number of bowel movement per week?_____ ☐ Require laxatives or enemas frequently

☐ Remove stool with finger sometimes ☐ Sense of incomplete emptying

Rectal ☐ No ☐ Yes If yes, for how long?_____

☐ Itching ☐ Swelling ☐ Soiling of stool ☐ Bleeding, Specify:

☐ Bright red blood ☐ Blood mixed in stool ☐ Blood on toilet paper

ENDOSCOPY HISTORY: ☐ None

☐ Upper endoscopy (EGD) *date, findings:* _____

☐ Colonoscopy *date, findings:* _____ Polyp(s) ☐Yes ☐ No

☐ ERCP *date, findings:* _____

☐ Endoscopic Ultrasound (EUS) *date, findings:* _____

☐ Flexible Sigmoidoscopy *date, findings:* _____

☐ Manometers studies *date, findings:*_____

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Prior issues with anesthesia: ☐ NO ☐YES If yes please Explain:_____

Bleeding tendencies: ☐ NO ☐YES If yes please explain:_____

PAST MEDICAL HISTORY: *Check ALL past or present illnesses* ☐ Not applicable

GASTROINTESTINAL:	☐ IBS	☐Hemorrhoids	☐Chron's Disease
	☐GERD/Reflux	☐Diverticulosis	☐Ulcerative Colitis
	☐Barrett's Esophagus	☐Diverticulitis	☐pancreatitis (acute/chronic)
	☐H. Pylori	☐Bowel obstruction	☐GI bleed
	☐Peptic Ulcer Disease	☐Gallstones	☐Hepatitis (A,B,C)
	☐Cirrhosis	☐Fatty liver	☐other: _____
CARDIAC:	☐Coronary Artery Disease	☐High Blood Pressure	☐cardiomyopathy
	☐Heart failure	☐High cholesterol	☐atrial fibrillation
	☐Heart attack	☐Heart valve disease	☐other: _____
PULMONARY:	☐Asthma	☐Sleep apnea	☐pulmonary embolus
	☐COPD	☐sarcoidosis	☐other: _____
NEUROLOGICAL:	☐Stroke	☐Dementia	☐seizure disorder
	☐TIA	☐Parkinson's	☐aneurysm
	☐headaches	☐Alzheimer's	☐other: _____
PSYCHIATRY:	☐anxiety	☐depression	☐other:_____
GENITOURINARY:	☐Kidney stones	☐Dialysis (MWF/TTHS)	☐uterine fibroids
	☐kidney disease	☐BPH	☐other: _____
INTEGUMENTARY:	☐Psoriasis	☐Vitiligo	☐other:_____
MUSCULOSKELETAL:	☐Rheumatoid arthritis	☐Lupus	☐Scleroderma
	☐Raynaud's	☐Sjogren's	☐Gout
	☐arthritis	☐scoliosis	☐other: _____
ENDOCRINOLOGY:	☐Diabetes(type I, II)	☐underactive thyroid	☐overactive thyroid
	☐Hyperparathyroid	☐Adrenal disorder	☐other:_____
HEMATOLOGY:	☐Clotting disorder	☐Iron overload	☐thalassemia
	☐Hemophilia	☐Anemia	☐platelet disorder
	☐Von Willibrand	☐Protein C/S deficiency	☐other:_____

ONCOLOGY: **Please specify if you have or had cancer and how it has or is being treated:**

_____

_____

OTHER:_____

_____

SURGICAL HISTORY: *Check any that apply and please specify dates:* ☐ Not applicable

☐ pacemaker	☐ defibrillator	☐ bariatric surgery (sleeve/band/bypass)	☐whipple
☐ colon resection	☐hernia repair	☐gallbladder surgery	☐appendix surgery
☐ cardiac bypass	☐cardiac stents (on Aspirin? Plavix? Brilinta? etc)		

Other:_____

_____

FAMILY HISTORY: *Check any diseases that run in your family and please indicate which family member is effected:* ☐ None

☐Chron's disease	☐ulcerative colitis	☐IBS	☐liver disease
☐celiac disease	☐colon polyps	☐colorectal cancer	☐stomach cancer
☐pancreatic cancer	☐esophageal cancer	☐bleeding disorder	☐

Other:_____

_____

Rajiv Bansal M.D.
Avigayil Neuburger, PA-C

PATIENT REGISTRATION

Date: _____

Name _____ SS# _____

Street Address _____ Birth Date _____ Sex M F

City _____ State _____ Zip _____

Home _____ Work _____ Cell _____

Email Address _____

Spouse's Name _____ Spouse's Phone # _____

Emergency Contact _____ Tel# _____ Relationship _____

REFERRING DOCTOR

Referring Doctor _____ Telephone _____

Street Address _____ City _____ State _____ Zip _____

PATIENT EMPLOYER INFORMATION

Employer Name _____ Occupation _____

Employer Address _____

City _____ State _____ Zip _____ Telephone _____ Ext _____

INSURANCE

Primary Insurance Company _____

ID# _____ Group # _____ Tel # _____

Secondary Insurance Company _____

ID# _____ Group # _____ Tel# _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFIT

- I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.
- I hereby authorize LIGHTe Associates to apply for benefits on my behalf for covered services rendered by him or his order.
- I am responsible for obtaining all appropriate referrals in accordance with my insurance plan.
- I certify that the information I have reported with regard to my insurance coverage is correct. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

DATE _____ SIGNATURE _____

2001 Marcus Ave., Ste E130
Lake Success, NY 11042
Tel: 516-437-6900
Fax: 516-437-6904

524 Old Country Rd.
Plainview, NY 11803
Tel: 516-496-1060
Fax: 516-437-6904

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PRIVACY NOTICE ACKNOWLEDGMENT

Acknowledgment of Receipt

A copy of the most recent privacy notice for our office will be given to each patient upon their first visit to our office or their return visit on or after April 14, 2003.

An acknowledgement that the patient has received our privacy notice is required under HIPPA regulations. To do this we will have each patient fill out and sign this form. It will then be placed in their medical record.

By signing below, I hereby acknowledge receipt of the Practice's Notice of Privacy Practices.

_____

Print Name

_____

Signature

_____

Date

If there is a revision to our privacy notice, we will promptly distribute and acknowledge this new notice of privacy practices. If you would like to authorize others to receive your sensitive health information, please list the names of the person and their relationship to you.

Name:	**Relationship:**
1) _____	_____
2) _____	_____
3) _____	_____
4) _____	_____

_____ _____

Your Signature Date

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PREFERENCE FOR COMMUNICATION

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that applies):

☐ Home Telephone _____

☐ O.K. to leave message with detailed information
☐ Leave message with call back number only

☐ Written communication

☐ O.K. to mail to my home address
☐ O.K. to mail to my/work/office address
☐ O.K. to fax to this number

_____

☐ Cell Number _____

☐ Work Telephone _____

☐ O.K. to leave message with detailed information
☐ Leave message with call back number only

☐ Other (List here any individual we may release medical information to)

Name _____ Relationship _____ Phone # _____
Name _____ Relationship _____ Phone # _____
Name _____ Relationship _____ Phone # _____
Name _____ Relationship _____ Phone # _____

_____ _____
Print Name Birth Date

_____ _____
Signature Date

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and request for PHI to the minimum necessary to accomplish the intended purpose. These provisions do no apply to uses or disclosures made pursuant to an authorization requested by the individual.

Health care entitles must keep records of PHI disclosers. Information provided above, if completes properly, will constitute an adequate record.

Note: Uses and disclosers for treatments may be permitted without prior consent in an emergency.

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OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:
Dr. Rajiv Bansal 2001 Marcus Ave. Ste E130 Lake Success, N.Y. 11042 (516) 437-6900 (P) (516) 437-6904 (F)

9(a). Specific information to be released:

- ❑ Medical Record from (insert date) _____ to (insert date) _____
- ❑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ❑ Other: _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**
_____ **Mental Health Information**
_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ❑ By initialing here _____ (Initials) I authorize _____ (Name of individual health care provider) to discuss my health information with my attorney, or a governmental agency, listed here:

_____
(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ❑ At request of individual ❑ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____
Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

Rajiv Bansal, M.D.
Avigayil Neuburger, PA-C

Cancellation Policy/ No Show Policy
For Appointments and Procedures

Office Visit Cancellation/ No Show:

We understand that there are times when you must miss an appointment due to emergencies or other unexpected events. However, if you to not call to cancel or reschedule your appointment, you may be preventing another patient from getting much needed treatment. Equally, the situation may arise where another patient fails to cancel and we are unable to accommodate you for a visit, due to a seemingly "full" schedule.

If you do not cancel your appointment at least 24 hours in advance, you may be charged a "No Show Fee" of $40. This will not be covered by your insurance.

Procedure Cancellation/ No Show:

Due to the large block of time needed for each procedure and intricacies in planning for it, last minute cancellations create multiple problems. We have many patients on a waiting list for urgent procedures. Cancelling or rescheduling more than 72 hours in advance will allow us enough time to reschedule a patient in need.

If you do not cancel your procedure at least 48 hours in advance, you may be charged a "No Show Fee" of $75. This will not be covered by your insurance.

_____	_____	____/____/____
Print Patient Name	**Signature Patient/Guardian**	**Date**

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