SUBURBAN GASTROENTEROLOGY

DINESH JAIN, M.D.
SCOTT BERGER, M.D.
SUSHAMA GUNDLAPALLI, M.D.
DARREN KASTIN, M.D.
GONZALO PANDOLFI, M.D.
SHIVANI KIRILUK, D.O.
PRAVEEN METTU, M.D.
ADITYA DHOLAKIA, D.O.

1243 Rickert Drive
Naperville, IL 60540

Telephone 630-527-6450
Fax 630-527-6456

Dear Patient,

Please fill out the enclosed information packet and return this to our office within 2 weeks of your procedure. We are sending with your packet our new Medical History. This card enables us to easily capture your medical history, family history, social history and risk factors. This will allow us to have them recorded in your electronic medical record prior to your visit with your physician

Please make sure this packet is completed and returned to our office 2 weeks prior to your procedure.

Sincerely,

Suburban Gastroenterology, Ltd.

Suburban Gastroenterology, LTD

Midwest Endoscopy Center, LLC
1243 Rickert Drive
Naperville, IL 60540

Billing Hand Out

Bills from Our Offices

- Facility Service Charges **- Midwest Endoscopy Center**
- Physician Professional Charges **- Suburban Gastroenterology**
- Pathology **- Suburban Gastroenterology**

Bills from Outside Companies (if applies)

- Anesthesia **-** billed directly by **Mobile Anesthesia**. They can be contacted at 866-997-7770
- Pathology **- Edward Hospital Laboratory & Pathology Diagnostics LLC** (Two Separate Bills)

We will receive a quote of benefits and/or pre-certification/predetermination for your procedure(s) from your insurance carrier. We encourage patients to also call their insurance company to receive a quote of benefits/notification prior to their procedure(s), so that they can be aware of their financial responsibility.

Your deductible and/or copay is due upfront on the date of the procedure. We will require your credit/debit card information for the remaining out of pocket you owe. This is charged to your card <u>after</u> your health insurance company has paid their portion and provided the exact amount you owe.

All estimates given are based on the average "allowable" amount, per your insurance carrier, for the baseline procedure being scheduled. It is fully understood that the cost given is an **ESTIMATE**; the actual amount may be different depending on the exact procedure/technique performed, such as polyps removed and/or abnormal findings, etc. After insurance has been settled, if there is a credit balance on either SGI or MWE account the Company with credit may transfer said funds to the other company. Any remaining credit balance after that will be refunded back to you.

How screening procedure is coded (if applies):

Our office has been asked to schedule you for a screening colonoscopy. Patients who are having a screening colonoscopy are considered to have no signs or symptoms or personal history of polyps and have a set benefit from their insurance company. **<u>You need to be informed that if the physician performing your procedure finds a polyp or abnormality, your benefits may change and your insurance company may pay differently (diagnostic benefits versus screening benefits.)</u>**

If you have any further questions or concerns, feel free to call our billing department at 630-527-6450 opt 6 or contact member services at the number listed on your insurance card.

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Insurance and Billing Policy

1. Suburban GI will submit claims to your insurance carrier for services provided by our physicians. These include office visits, consultations and surgical procedures. Surgical procedures (colonoscopies, gastroscopies and flexible sigmoidoscopies) are billed as "out-patient surgery".
   Unless otherwise requested, all biopsies performed in our facility will be read by our in house pathologist which will be billed by Suburban Gastroenterology, LTD. All second opinions will be submitted to Edward Hospital pathology, and/or the University of Chicago Hospital. Therefore, it is the patient's responsibility to contact their insurance company to verify that Edward pathologists, Dianon systems and the University of Chicago Hospital are contracted with your particular PPO or HMO plans. Please inform our office/staff if your insurance company is not contracted with the above or the patient has any objections with Suburban GI using these facilities.

2. **Payment for insurance copays and deductibles will be collected on the day services are rendered**. If no insurance is applicable, financial arrangements must be finalized before any services are rendered

3. Suburban GI will call and verify insurance eligibility and request a "general description" of insurance benefits. It is **ultimately the responsibility of the patient** to know their particular plan, as the insurance company will not guarantee payment of the benefits they quote.

4. For those patients enrolled in the HMO or managed care products, Suburban GI will contact the primary care physicians referral coordinator to "initiate" referrals for surgical procedures. It is the patient's responsibility to follow through with the primary care office and have the referral "in hand" the day of the procedure.

5. Please notify our insurance department immediately of any changes in your insurance plan or carrier.

A copy of this serves as the original document.

_____ _____

Name of Patient DOB

_____ _____

Signature of Patient or Legal Representative (if applicable) Date

_____

Name of Legal Representative and relationship to patient (if applicable)

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CONSENT FOR RELEASE OF INFORMATION FOR THE TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I, _____, hereby authorize Suburban Gastroenterology, Ltd. to use and or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, Suburban Gastroenterology, Ltd. can refuse to treat me.

I have received a copy of the Notice of Privacy Standards which more fully describes the uses and disclosures that can be made of my individually identifiable health information for the treatment, payment and health care options.

I understand that Suburban Gastroenterology, Ltd. has reserved the right to change my privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request that Suburban Gastroenterology, Ltd. restricts how my individually identifiable health information is used and or disclosed to carry out treatment, payment or health operations. I understand that Suburban Gastroenterology, Ltd. does not have to agree to such restrictions, but that once such restrictions are agreed to Suburban Gastroenterology, Ltd. must adhere to such restrictions.

_____ _____
Name of Patient DOB

_____ _____
Signature of Patient or Legal Representative (if applicable) Date

_____
Name of Legal Representative and relationship to patient (if applicable)

SUBURBAN GASTROENTEROLOGY, LTD

MIDWEST ENDOSCOPY CENTER, LLC

CONSENT TO RELEASE OF HEALTH INFORMATION

It is the policy of Suburban Gastroenterology, Ltd. and Midwest Endoscopy Center, LLC (collectively, the "Practice") not to release information about your medical care, condition and/or test results via telephone, e-mail, answering machine/voice mail, cellular phone or fax, or to certain third-parties, without your permission.

Please select whether we may contact you by any of the following methods. ***By making a selection, you give the Practice permission to share information with you regarding your medical care, condition and/or test results through the methods selected below*** (select all that apply and provide the requested information):

May we contact you via your home telephone # _____?	____YES	____NO
May we leave messages on your home telephone answering machine/voicemail?	____YES	____NO
May we contact you via your work telephone # _____?	____YES	____NO
May we leave messages on your work telephone answering machine/voicemail?	____YES	____NO
May we contact you via your cellular telephone # _____?	____YES	____NO
May we leave messages on your cellular telephone voicemail?	____YES	____NO
May we contact you via fax # _____?	____YES	____NO
May we contact you via e-mail address _____?	____YES	____NO
May we contact you via Mychart?	____YES	____NO

(Please note that notification of portal messages are sent to your e-mail address you provide)

If information regarding your medical care, condition and test results can be released to someone other than yourself, please complete the following:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

By signing below, I acknowledge that it is my responsibility to update the Practice of any changes to the contact information set forth above. My authorizations will remain in effect until terminated by me in writing, which I may do at any time; however, I understand that my revocation will not affect any communications made prior to such revocation. I acknowledge that the Practice cannot ensure the security of electronic communications and messages, including, but not limited to, the use of unencrypted e-mail. I understand that the content of this consent does not prevent the Practice from disclosing information about my medical care, condition and/or test results for treatment, payment or health care operation or as otherwise allowed by law, and my consent will not be specifically required for those purposes.

_____ _____

Name of Patient DOB

_____ _____

Signature of Patient or Legal Representative (if applicable) Date

_____

Name of Legal Representative and relationship to patient (if applicable)

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SUBURBAN GASTROENTEROLOGY

Appointment Policy

At Suburban Gastroenterology, Ltd., we put our faith in you to keep your appointment. Many offices double book appointments to prevent from being financially damaged as a result of a missed appointment. We choose to not do this. We prefer to give the appropriate care and attention to each patient and provide excellent care.

If for any reason you must cancel or change your Suburban Gastroenterology office appointment, it is important that you give our office **at least two business days' notice** to offer that appointment to someone else. If you fail to do this, there will be **a $50.00 fine** assessed.

We understand that true emergencies do occur. Under these circumstances a doctor's note or other appropriate documentation will be considered to have the charge waived.

_____ _____

Name of Patient **DOB**

_____ _____

Signature of Financially Responsible Party **Date**

MIDWEST ENDOSCOPY CENTER, LLC.

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Appointment Policy

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If for any reason you must cancel or change your Midwest Endoscopy Center procedure appointment, it is important that you give our office **at least three business days' notice** to offer that procedure time to someone else. If you fail to do this, there will be a **$100.00** fine assessed.

We understand that true emergencies do occur. Under these circumstances a doctor's note or other appropriate documentation will be considered to have the charge waived.

_____ _____

Name of Patient **DOB**

_____ _____

Signature of Financially Responsible Party **Date**

Midwest Endoscopy Center

1243 Rickert Drive, Naperville, IL 60540

WHAT WE ARE: We are an endoscopy center licensed in the State of Illinois, and accredited by Medicare and AAAHC.

WHO WE ARE: We are owned jointly by Edward Health Ventures and by physicians Dinesh Jain, MD, Scott Berger, MD, Sushama Gundlapalli, MD, Darren Kastin, MD, Gonzalo Pandolfi, MD and Shivani Kiriluk, DO. We were developed to provide a safe and comfortable endoscopy facility that would provide efficient and effective services to patients.

WHY WE WERE OPENED: Outpatient care has been proven to increase patient comfort through personalized care while delivering quality services. Dinesh Jain, MD and Scott Berger, MD joined together to open Midwest Endoscopy Center to provide personal attention and quality services to their patients in and around DuPage County.

YOUR RIGHTS AS A PATIENT: You have the right to choose the provider and the facility for your health care services. You will not be treated differently by your physician if you obtain health care services at another facility.

YOUR CHOICE: Your physician may have ownership interest in the Center. Please discuss with your gastroenterologist your questions or concerns, if you want to have your procedure at an alternative health care facility.

CREDENTIALS: All of the physicians and anesthesiologists have been credentialed according to AAAHC standards. Information is available upon request.

PATIENT GRIEVANCES: If patients have complaints or concerns in regard to your care at Midwest Endoscopy Center they are encouraged to fill out a grievance form, which is available upon request at the front desk. Contact numbers are available now.

MALPRACTICE INSURANCE: Your physician has malpractice insurance to meet the State of Illinois requirements or more.

ADVANCE DIRECTIVES: If you have an advance directive/living will, be advised that the center will not honor any advance directive/living wills that do not allow resuscitation. It is the policy of the center to transfer any patient requiring resuscitation to the hospital. The hospital can determine when to implement the advance directive/living will once the patient or others notify them of the advance directive/living will. You have a right to have your living will present in our medical record at the Center and to be informed of the Center's policy prior to the date of admission. State information and forms to prepare an advance directive, if you decide to have one, can be found at the following website: **http:**//www.idph.state.il.us/public/books/advin.htm

Consumer Complaints for the IL Department of Health and Senior Services can be made at: http:www.dhs.state.il.us/page.aspx?item=27894

For Medicare: Offices of the Medicare Ombudsman at www.cms.hhs.gov/center/ombudsman.asp

I have received and read the above information

Patient Signature: _____ **DOB:** ____/____/____ **Date:** _____

Patient Print Name: _____**Witness:**_____**Date:**_____

Please return to Midwest Endoscopy Center prior to your procedure*

PATIENT'S BILL OF RIGHTS AND RESPONSILIBITIES

The staff of this health care facility recognizes you have rights while a patient receiving medical care. In return, there are responsibilities for certain behavior on your part as the patient. There Rights and Responsibilities include:

A patient has the *right* to:

- Be treated with courtesy and respect, with appreciation of his individual dignity, and with protection of his need for privacy.
- A prompt and reasonable response to questions and request.
- Know who is providing medical services and who is responsible for his care.
- Know what patient support services are available, including whether an interpreter is available if he does not speak English.
- Know what rules and regulations apply to his conduct.
- Be given by his health care provider information concerning diagnosis, a planned course of treatment, alternatives, risks, and prognosis.
- Refuse treatment, except as otherwise provided by law.
- Be free from all forms of abuse and harassment.
- A patient can exercise their rights without being subject to discrimination or reprisal.
- Be given, upon request, full information and necessary counseling on the availability of known financial resources for his care.
- Know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.
- Receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- Receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have charges explained.
- Impartial access to medical treatment of accommodations, regardless of race, national origin, religion, physical disability, or source of payment.
- Treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- Know if medical treatment is for purposes of experimental research and to give his consent or refusal to participate in such experimental research.
- Express concerns regarding any violation of patient rights.
- Have the right to change primary or specialty physicians or dentists if other qualified physicians or dentists are available.

A Patient is *responsible* for:

- Providing to his health care provider, to the best of his knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his health.
- Reporting unexpected changes in his condition to his health care provider.
- Reporting to his health care provider whether he comprehends a contemplated course of action and what is expected of him.
- Following treatment plan recommended by his health care provider.
- Keeping appointments.
- His actions if he refuses treatment or does not follow the health care provider's instructions.
- Assuring that the financial obligations of his health care are fulfilled as promptly as possible.
- Following health care facility rules and regulations affecting patient care and conduct.
- If any procedure for which you require sedation you must have a responsible adult companion who can take you home.

COMPLAINTS

If you have a question or concern about your Rights and Responsibilities, please let us know. We want to assure that we provide you with excellent services, including answering your questions and responding to your concerns.

_____ Dr. Scott Berger, Medical Director

You may also choose to contact the IDPH
Office of Health Care Regulation at 217-782-2913

You may also choose to contact the licensing agency of the state,
Agency of Health Care Administration at 1-888-419-3456

If you are covered by Medicare, you may choose to contact the Medicare Ombudsman at:
1-800-MEDICARE (1-800-633-4227) or online at www.Medicare.gov

You may also choose to contact Accreditation Association for Ambulatory Health Care, Inc. (AAAHC)-847-853-6061

Disclosure Statement: If you are scheduled for a procedure at Midwest Endoscopy Centers, LLC, your healthcare provider is referring you to a facility or service in which Suburban Gastroenterology, LTD providers have a financial or economic interest.

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SUBURBAN GASTROENTEROLOGY, LTD

1243 Rickert Drive, Naperville, IL 60540 Telephone 630-527-6450 Fax 630-527-6456

Patient Name: _____ DOB: _____

Weight: _____ Height: _____

ALLERGIES TO MEDICATIONS: _____

ALLERGIES TO FOODS: _____

MEDICAL HISTORY: (Circle all that apply)

Gastrointestinal

-Abdominal distention
-Abdominal pain
-Belching
-Black Stools
-Bloating
-Blood in stool
-Constipation
-Diarrhea
-Food/Milk Intolerance
-Gas/Flatulence
-Get full quickly at meals
-Hemorrhoids
-Hernia
-Incontinence of stool
-Indigestion
-Irregular bowel habits
-Jaundice
-Laxative Use
-Nausea
-Pain with bowel movements
-Painful swallowing
-Swallowing problems
-Vomiting
-Vomiting Blood

General

-Fatigue
-Fever
-Loss of appetite
-Night sweats
-Sleep disturbance
-Weight gain
-Weight loss

Neurological

-Dementia
-History of Stroke
-Recent dizziness
-Recent passing out
-Seizures

Cardiovascular

-Automatic Defibrillator
-Chest Pain or Pressure - after eating or when upset
-Chest Pain or Pressure with exertion (angina)
-High cholesterol
-History of heart murmur
-History of rheumatic fever
-Irregular heart - rate/palpitations
-Leg swelling
-Other implanted devices
-Pacemaker
-Stents

Respiratory

-Chronic Cough
-Chronic or frequent hoarseness
-Cough up sputum
-Exposure to tuberculosis
-Shortness of breath
-Sleep apnea
-Spitting up blood
-Wheezing

Genitourinary

-Blood in urine
-Frequent urinary infections
-Frequent urination
-History of kidney stones
-Kidney Failure
-Leaking urine
-Painful/difficult urination

Endocrine

-Diabetes mellitus
-Thyroid disease

Psychosocial

-Anxiety
-History of depression
-History of eating -disorder
-History of mental illness
-History of physical or sexual abuse
-Stress
-Usually feel lonely or depressed

Skin

-Body piercing
-Change in hair or nails
-Flushing
-Rash
-Severe itching
-Tattoos
-Unusual moles

Bone & Joint

-Arthritis
-Back pain
-Joint pain
-Osteoporosis

Blood

-Anemia
-Easy bruising
-Enlarging or painful lymph nodes
-Excessive bleeding

Eyes

-Blurred/double vision
-Eye Disease
-Glasses or contacts
-Glaucoma

Ear/Nose/Throat

-Bad breath or bad taste in mouth
-Hearing loss
-Mouth sores
-Nose or gums bleeding

SURGICAL HISTORY: (CIRCLE)

-Angioplasty
-Aortic aneurysm
-Appendectomy
-Back surgery
-Bowel resection
-CABG
-Cholecystectomy
-Colon resection
-Colon resection w/colostomy
-Colonoscopy
-EGD
-ERCP
-Flexible Sigmoidoscopy
-Gastric Bypass
-Heart valve
-Hemorrhoidectomy
-Hernia surgery
-Hip replacement
-Knee replacement surgery
-Liver biopsy
-Lysis of adhesions
-Pacemaker
-Prostatectomy
-Spine
-Thyroidectomy
-Tonsillectomy
-Transplant

Family History

	Relationship to the patient: (Please list if maternal or paternal side of the family)
Colon Cancer	
Breast Cancer	
Ovarian Cancer	
Uterine Cancer	
Prostate Cancer	
Crohn's Disease	
Ulcerative Colitis	
Bleeding Disorder	
Colon Polyps	
Alcohol and other disorders associated	
Diabetes	
Hypertension	
Heart Attack	
Stroke	
Sickle Cell	
Mental Disorder	

Other: _____

Substance (Circle)

Do you smoke? No Yes Former Smoker Packs per day? _____Years? _____

Smokeless Tobacco: Current User Former User Never Used

Consume Alcohol? No Yes

Drinks/Week: # Glasses of wine _____ # Cans of beer _____ #Shots of Liquor_____ #Standard drinks or equivalent _____

Drug Use? No Yes

Indicate if you had any of the gastrointestinal conditions listed: (Circle)

-Barrett's Esophagus
-Irritable Bowel Syndrome
-Anal fissure
-Intestinal infection
-Diverticulitis
-Gastrointestinal bleeding
-Chronic constipation
-Yellow skin or jaundice
-Colon polyps
-Acid reflux/GERD
-Hepatitis C
-History helicobacter pylori
-Gallbladder problems
-Stomach or duodenal ulcer
-Diverticulosis
-Hemorrhoids
-Autoimmune
-Colitis/Ulcerative
-Celiac disease
-Esophageal stricture or narrowing
-Crohn's disease
-Alcohol abuse
-Pancreatitis

Indicate if you had any of the non-gastrointestinal conditions listed: (Circle)

-High blood pressure
-Abnormal heartbeat/palpitations
-HIV positive
-Bleeding disorder
-Stroke
-Fibromyalgia
-Emphysema or COPD
-Treatment with blood thinner
-Exposure to HIV
-Arthritis
-Asthma
-Blood clots
- Congestive Heart Failure
-Heart disease/Heart attack
-Thyroid disease
-High cholesterol
-Anemia
-Hypothyroid (low)
-Hardening of the arteries
-Multiple Sclerosis
-Seizure disorder
-Lupus
-Diabetes

Indicate if you had any of the types of Cancer listed: (Circle)

-Mouth/throat
-Blood (Leukemia)
-Uterus
-Esophagus
-Prostate
-Ovaries
-Stomach
- Lungs
- Skin
- Colon or rectum
- Breast
- Pancreas

Other: _____

What is your current relationship status: (Circle)

Divorced Married Separated Significant other Widowed Other

Do you live alone: (Circle)

Yes No

How many caffeinated beverages do you consume per day: (Circle)

None Occasional 1-2 3-5 More than 5

Have you traveled outside of the US in the past 6 months: (Circle)

Yes No

Have you engaged in high risk sexual behavior: (Circle)

Yes No

Have you ever had a blood transfusion: (Circle)

Yes No

Are you taking any fiber supplements: (Circle)

Yes No

Has your stool tested positive for blood: (Circle)

Yes No

Have you ever had x-rays, CT, or ultrasound of your abdomen or GI tract: (Circle)

Yes No

Please mark all GI tests that you have had: (Circle)

Colonoscopy Upper Endoscopy Flexible sigmoidoscopy ERCP (Endoscopy of Bile duct or pancreas)

Do you have an advance directive: (Circle)

Yes No

Do you have a defibrillator or pacemaker: (Circle)

Yes No

Have you previously had C. Diff: (Circle)

Yes No

Have you previously had MRSA: (Circle)

Yes No

MEDICATION LIST: (If you have more than 15 medications please attach a list of your medications)

NAME OF MEDICINE	DOSAGE	# PER DAY
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

Updated:1/12/2018