GASTROENTEROLOGY
CENTER *of* NEW YORK
Jason Rubinov, MD

PATIENT REGISTRATION FORM

Patient's Name (Last, First, MI): _____

Patient's Home Phone Number: _____ Alternate Phone Number (☐ cell or ☐ work): _____

E-Mail Address: _____

Address: _____ Apt. # _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ Sex: ☐ M ☐ F Social Security Number: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Pharmacy Name	Pharmacy Location	Pharmacy Phone
Primary Care Physician	Primary Physician Location	Primary Physician Phone
Referring Physician	Referring Physician Location	Referring Physician Phone
Patient's Employer:	Employment Status: ☐ Full time ☐ Part time ☐ Unemployed ☐ Retired ☐ Student ☐ Other: _____	

Emergency Contact: _____ Relationship to Patient: _____

Address: _____ Phone number: _____

INSURANCE INFORMATION

Primary Insurance: _____

Patient is Subscriber/Policy Holder: ☐ Y ☐ N

Secondary Insurance: _____

Patient is Subscriber/Policy Holder: ☐ Y ☐ N

INSURED INFORMATION (IF OTHER THAN PATIENT) - We will request to scan your ID and insurance card

Subscriber/ Policy Holder: _____ Relationship to Patient: _____

Address: _____

Social Security Number: _____

Date of Birth: _____

His or Her Employer: _____ Work Phone Number: _____

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HEALTH HISTORY

Personal Information: Date:_____

Patient Name: _____ Birth Date: _____/_____/_____ Age: ____

Referring Doctor: _____

Preferred Language: ☐ English ☐ Spanish ☐ Russian ☐ Other _____

Reason for Today's Visit:

_____

Medical Information:

Please list any **MEDICATIONS** you are currently taking, prescribed or over the counter (use the back of the page if needed and indicate so):

Medication	Dosage	Route	Frequency

Any **Allergies** to Medication or Food (list reactions): _____

Social Information:

Tobacco Use: Do you or have you ever smoked? ☐ Current ☐ Former

If so, how many cigarettes/cigars per day: _____ No. of years smoking: _____

Do you chew tobacco? ☐ Yes ☐ No Have you thought about quitting? ☐ Yes ☐ No

Alcohol Use: Do you drink alcohol? ____ If so, what type? _____ How many in 1 week? _____

Drug Use: Any history of illegal drug use? _____ If so, what type/s? _____

Are you on any special **diet**? _____ If so, what? _____

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PAST MEDICAL HISTORY

Do you now or have you ever had:

- ❑ Colon Polyps
- ❑ Heartburn/Reflux
- ❑ Crohn's Disease
- ❑ Ulcerative Colitis
- ❑ Irritable Bowel Syndrome
- ❑ Celiac Disease
- ❑ Gallstones
- ❑ Hemorrhoids
- ❑ Liver Disease
- ❑ Hepatitis B
- ❑ Hepatitis C
- ❑ Stomach Ulcer
- ❑ Cancer (type) _____
- ❑ Heart Disease
- ❑ Diabetes
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Hypothyroidism
- ❑ Heart Arrhythmia
- ❑ Kidney Disease
- ❑ Blood Clots
- ❑ Pulmonary Embolism
- ❑ Anemia
- ❑ Asthma
- ❑ Emphysema
- ❑ Stroke
- ❑ Epilepsy (seizures)
- ❑ Anxiety
- ❑ Depression
- ❑ HIV/AIDS

Other Medical Conditions (please list):

_____

_____

Please list any **SURGERIES** you have had and include the month/year:

_____

_____

_____

_____

Any **FAMILY HISTORY** of medical conditions:

- ❑ Colon Polyps
- ❑ Colon Cancer
- ❑ Stomach Cancer
- ❑ Liver Cancer
- ❑ Pancreatic Cancer
- ❑ Crohn's Disease
- ❑ Ulcerative Colitis
- ❑ Celiac Disease
- ❑ Liver Disease
- ❑ Hepatitis B ❑ Hepatitis C
- ❑ Stomach Ulcer
- ❑ Cancer (type) _____
- ❑ Heart Disease
- ❑ Diabetes
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Hypothyroidism
- ❑ Kidney Disease

Other Medical Conditions (please list):

_____

_____

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1. **Assignment and Coordination of Insurance Benefits** - I agree to provide information regarding all group hospitalization, health maintenance organization, Workers' Compensation, automobile, and other health care benefits ("Insurance Plan(s)") to which I may be entitled. I hereby assign payment(s), if any, from my Insurance Plan(s) to Jason Rubinov, MD (or its affiliate) and each of the independent contractor physicians and/or professional corporations for services rendered to me. The direct payment hereby assigned and authorized includes any Insurance Plan(s) benefits to which I am otherwise entitled, including any major medical benefits otherwise payable to me under the terms of my policy, but is not to exceed the balance due to the Jason Rubinov, MD (or its affiliate), the independent contractor physicians and/or professional corporations for services rendered to me during the applicable periods of medical care.

2. **Unauthorized, Non-Covered, or Out of Plan Services** - I understand if my Insurance Plan(s) does not consider this admission or any service rendered during this admission a covered service or has not authorized this service, they will not pay for this admission or the service rendered during this admission or outpatient visit. I agree to be fully responsible for payment to Jason Rubinov, MD for this admission or any service if determined by my Insurance Plan(s) to be a non -covered service. I also understand and acknowledge that in the case of Out of Plan/Network services, there may be reduced benefits and I may be required to pay a larger co-payment, co-insurance or other charge In the event my Insurance Plan(s) does not reimburse these services provided to me, I acknowledge I will be responsible for any remaining balance.

3. **For Medicare Recipients Only** - I certify the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made on my behalf to the Hospital and/or independent contractors for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for the related services. In the case of Medicare Part B benefits, I request payment either to myself or to the party who accepts assignment.

4.**Release of Information -** I hereby authorize the release of any confidential medical information, including information related to psychiatric care, drug and alcohol abuse and HIV/AIDS, necessary to process insurance claims or any other medical information that is required for any health care required for any health care related utilization review or quality assurance activities or to any heath care professional requiring this information in order to treat me.

I hereby give permission to the person(s) listed below to receive information about the care of the above named patient.

Name(s): _____

Relationship to Patient: _____

4. **Privacy:** I certify that I have been made aware of Jason Rubinov, MD's **Notice of Privacy Practices** and that I have a right to receive a copy upon request. This Notice describes the type of uses and disclosures of my protected health information that might occur during my treatment, to facilitate the payment of my bills or in the performance of Jason Rubinov, MD's health care operations. The Notice also describes my rights and Jason Rubinov, MD's duties with respect to my protected health information. I understand that copies of the **Notice of Privacy Practices** are available in the office registration area and can be requested to be mailed to me.

Jason Rubinov, MD reserves the right to change the privacy practices that are described in the **Notice of Privacy Practices**. I may obtain a revised **Notice of Privacy Practices** by calling the above number and requesting a revised copy be mailed to me, by asking for one at the time of my next appointment, or by accessing Jason Rubinov, MD's web site to view the most current version.

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5. **Consent for Electronic Communication**: I agree to communicate via e-mail or electronic messaging on matters related to my own health and/or medical treatment. I understand that any confidential health information that I send to the practice will be handled in strict accordance with the Gastroenterology Center of New York Privacy Policy but that it is not secure and is sent at my own risk. I will not hold the practice, nor any of its workforce members, liable for the breach of any confidentiality associated with information transmitted via email.

I also understand that it is not the policy of the practice to encrypt any confidential health information I request to be sent to me via e-mail. Because this information is not encrypted, I understand that it is not secure, I acknowledge the risk and will not hold the practice or any of its workforce members liable for any loss of confidentiality associated with such transmissions.

6. **Consent to Treatment:** I do hereby consent to and authorize the performance of all treatments, surgeries and medical services deemed advisable by the physicians and staff of the Gastroenterology Center of New York (or its affiliate) to me or to the above-named individual of whom I am the legal guardian.

7. **Contact Rules:**

I ❑ **DO** ❑ **DO NOT** authorize **Jason Rubinov, M.D.** to leave messages on my home answering machine regarding appointments and to inform them that laboratory results are available. I realize I must call the office to obtain laboratory results.

I ❑ **DO** ❑ **DO NOT** authorize **Jason Rubinov, M.D.** to contact me at work or leave messages for me at work.

8. **Transfer:** I understand that in case of an emergence at any of our offices, I will be transferred to the nearest hospital emergency room.

9. **No Show/Cancellation Policy:** The Gastroenterology Center of New York (or its affiliate) and Jason Rubinov, M.D. reserves the right to charge a fee for any scheduled visits that are:

1. Cancelled with less than 24 hours notice
2. Are missed without calling to cancel (no show)

Cancellation Fee schedule: Office Visit: $50.00; Procedure: $150.00

By signing below, I certify I have read and understand the foregoing, have had the opportunity to ask questions and have them answered and accept the above conditions and terms and I agree to pay all charges for which I may be legally responsible including, but not limited to health insurance deductibles, co-payments, and non-covered. I also agree in the event my account must be placed with an attorney or collection agency to obtain payment, I will pay the reasonable attorneys' fees and other collection costs incurred by Jason Rubinov, MD. *I understand and agree this document will remain in effect for all future outpatient or physician office visits to Jason Rubinov, MD, unless specifically rescinded in writing by me.*

Patient Signature: _____ Date: _____

Relationship to Patient: _____