Please bring this packet filled out with you to your appointment on _____ at_____

PLEASE BRING INSURANCE CARD(S) & PHOTO ID TO THIS APPOINTMENT

ALL COPAYS ARE DUE AT THE TIME OF THE VISIT

South Island Gastroenterology Associates, PC

Dr. Steven L. Kadish & Dr. Jonathan Zinberg

141 Washington Ave, Suite 204 Lawrence, NY 11559

Phone (516)341-0990 Fax (516)341-0987

PLEASE PRINT CLEARLY!

First Name: _____ Last Name: _____

DOB: _____Sex: _____Marital Status:_____

Address: _____

City: _____ State: _____ Zip Code: _____

Cell No.: _____ Home No.: _____

E-Mail: _____

Circle one:

RACE: American Indian or Alaska Native Asian White

Native Hawaiian or Other Pacific Islander Black or African American

Hispanic Other Race Unreported/Refuse to Report

Ethnicity: Not Hispanic or Latino Hispanic or Latino Refuse to Report

---

Language: _____

Pharmacy name: _____

Pharmacy address: _____

Pharmacy phone No.: _____

Primary care Doctor: _____

Any Specialty Doctors: _____

INSURANCE

Primary Insurance:	*Secondary Insurance:*
Insurance Name: _____	Insurance Name: _____
Member ID #: _____	Member ID#: _____
Group Name or #: _____	Group Name or #: _____
Insurance Address: _____	Insurance Address: _____
Insurance Phone No.: _____	Insurance Phone No.: _____

<u>If someone holds YOUR insurance policy, please provide the following information:</u>

Relation to insured: _____

Insured name: _____

Insured DOB: _____

Insured phone No.: _____

Insured address, only if different than yours:

_____

<u>Emergency Contact:</u>

Name:_____

Relationship:_____

Phone No.:_____

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ASSIGNMENT OF BENEFITS

CONFIRMATION OF FINANCIAL REPONSIBILIY

I (the Patient as noted below) hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled directly to:

SOUTH ISLAND GASTROENTEROLOGY ASSOCIATES, P.C.

for any medical serviced rendered to myself and/or my dependents.

Regardless of my insurance benefits, if any, I understand that I am RESPONSIBLE for any amount not covered by my insurance.

I have requested medical services from the physicians of SOUTH ISLAND GASTROENTEROLOGY ASSOCIATES, P.C. on behalf of myself and/or by the referral of my primary care and referring physician, and understand that by making this request, I become fully FINANCIALLY RESPONSIBLE for any and all charges incurred in the course of the treatment authorized.

I understand there will be separate claims filed to my insurance for Anesthesia and Pathology.

_____ _____

Patient Name (please spell full name) Date

_____

Patient Signature

South Island Gastroenterology Associates, PC
Dr. Steven L. Kadish & Dr. Jonathan Zinberg

FINANCIAL POLICY

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

You are responsible for the timely payment of your account including all co-payments, co-insurance, deductibles and non-covered services.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE

IF WE DO NOT PARTICIPATE WITH YOUR INSURANCE PLAN, PAYMENT PLAN MUST BE ARRANGED PRIOR TO YOUR VISIT.

IF WE PARTICIPATE WITH YOUR INSURANCE CARRIER, WE WILL SUBMIT A CLAIM FOR PAYMENT AT THE TIME THE SERVICES ARE RENDERED.

IF YOUR PLAN REQUIRES AUTHORIZATION FROM A PRIMARY CARE PHYSICIAN, IT IS YOUR RESPONSIBILITY TO OBTAIN THE WRITTEN REFERRAL OR AUTHORIZATION PRIOR TO YOUR VISIT WITH THE DOCTOR. IF YOU HAVE NOT DONE SO, YOU WILL BE RESPONSIBLE FOR FULL PAYMENT AT THE TIME OF THE SERVICE. OTHERWISE, YOUR APPOINTMENT MAY BE RESCHEDULED WHEN THE AUTHORIZATION IS OBTAINED.

INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. WE FILE INSURANCE CLAIMS AS A COURTESY TO OUR PATIENTS. WE WILL NOT BECOME INVOLVED IN DISPUTES BETWEEN YOU AND YOUR INSURANCE COMPANY REGARDING DEDUCTIBLES, CO-INSURANCE, CO-PAYMENTS, REFFERALS, "USUAL & CUSTOMARY CHARGES", ETC., OTHER THAN TO PROVIDE FACTUAL INFORMATION AS NECESSARY.

IN ORDER TO PROVIDE YOU WITH THE HIGHEST LEVEL OF CARE; A MEDICAL ENCOUNTER MAY INVOLVE THE PARTICIPATION OF MANY PHYSICIANS IN YOUR TREATMENT. FOR INSTANCE, A PROCEDURE MAY INVOLVE YOUR GASTROENTEROLOGIST, ANESTHESIOLOGIST, AND PATHOLOGIST. EACH OF THESE SERVICES IS BILLED.

IF YOU HAVE NOT PAID THE DOCTOR, AND YOUR INSURANCE COMPANY INADVERTENTLY PAYS YOU DIRECTLY, YOU MUST SEND THIS PAYMENT IMMEDIATELY TO THE DOCTOR.

TO THE EXTENT NECESSARY TO DETERMINE LIABILITY FOR PAYMENT AND TO OBTAIN REIMBURSEMENT, I AUTHORIZE THE DISCLOSURE OF PORTIONS OF THE PATIENT'S RECORD AS REQUESTED BY THE INSURANCE CARRIERS.

I HAVE READ THE ABOVE FINANCIAL POLICY AND AGREE TO ABIDE TO THE INFORMATION.

_____ _____

Patient or Guarantor's signature Date

_____

Print name of Patient or Guarantor

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CANCELLATION AND NO SHOW POLICY

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide more than 24 hours' notice. This will enable for another person who is waiting for an appointment to be scheduled in that appointment time slot. With cancellations made less than 24 hours notice, we are unable to offer that slot to other people.

Office appointment which are cancelled with less than 24 hours' notification may be subject to a **$50.00** cancellation fee. Procedure cancellations require 5-7 business day advance notice, without notification they may be subject to a **$150.00** cancellation fee.

Patients who do not show up or their appointment without a call to cancel an office appointment or procedure appointment will be considered as a NO SHOW. Patients who No-Show two (2) or more times in a 12-month period, may be dismissed from the practice thus they will be denied any future appointments. Patients may also be subject to a **$50.00 fee for office appointment No-Show and $150.00 procedure No-Show fee.**

The Cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

We understand that Special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval.

Our practice believes that good physician/patient relationship is based upon understanding and good communication. Questions about cancellation and no show fees should be directed to the Office Manager (516-341-0990).

Please sign that you have read, understand and agree to this Cancellation and No Show Policy.

_____ **Date of birth** _____

Patient Name (Please Print)

_____ _____

Signature of Patient or Patient Representative **Date**

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INDIVIDUALS/FAMILY MEMBERS

It is the responsibility of South Island Gastroenterology Associates P.C. to ensure that the information regarding patients remains confidential. This means that information regarding your medical condition, billing and insurance issues, or any other protected health information as identified under HIPAA, cannot be released to other people, not even to family members, unless you authorize, in writing, the person(s) to whom you want that information released.

In the event of a critical episode, or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

We realize that there are times when you may want another person to be knowledgeable about your medical condition, or act on your behalf about billing or insurance issues. You can, if you desire, name a person(s) to whom you want the office staff to speak with about your medical condition or other issues. To do this, you must complete the form listed below.

- The authorization is valid until you cancel it in writing.
- If you designate no one, South Island Gastroenterology Associates, P.C. cannot release information to any family member or friend.

AUTHORIZATION:

I_____ Date of Birth _____, authorize South Island Gastroenterology Associates, P.C. to release any and all information concerning my medical care to the following individuals. I release South Island Gastroenterology Associates, P.C and its staff from any claim of confidentiality in connection with the release of this information.

Name_____

Relationship to Patient_____ Phone Number_____

Name_____

Relationship to Patient_____ Phone Number_____

_____ I do not wish to designate anyone at this time.

_____

Patient Signature Date

_____

Patient Name(Please Print)

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NAME:_____**DOB**:_____**DATE**:_____

Reason for your visit today: _____

Current Medication(s)(drugs, pills) :

_____
_____
_____
_____
_____
_____
_____
_____

Medical History/Problems:

_____
_____
_____
_____
_____
_____
_____
_____

Previous Surgeries & Dates:

_____
_____
_____
_____
_____

Allergies:

_____
_____
_____
_____
_____

Are you pregnant? ____yes ____no

Height_____ft ____inches

Weight_____LB