Digestive Health Center of Englewood
Steven D. Gillon, D.O.

Patient Information and Authorization

Welcome to our practice. We are dedicated to providing you with comprehensive medical care.

In order to do so, we need accurate information about you and your health insurance-and your cooperation. Please read this form carefully, fill out the requested information and then sign it. Please notify us of any changes in any of the information so that we can keep your care uninterrupted.

Accuracy of information.

We participate with most Insurance plans. If you do not have insurance currently in force, or if you do not provide us with accurate insurance coverage information- ***In advance*** of your appointment, you will be responsible for payment of the charges.

If you cannot pay for the costs of treatment, please see the patient representative to make arrangements for payment- before seen by a physician. You are responsible for the payment arrangement that you agree to.

Appointments.

Please note your appointment- that time is reserved for you. If you must cancel an appointment, call us as soon as possible. Because this time is reserved, our policy must be to charge for any missed appointments or any appointments cancelled within one business day of appointed time. A regularly scheduled appointment time cannot be reserved if there have been two cancellations.

Authorizations.

Some managed care plans *require* an authorization form for the initial visit or for subsequent visits. Please forward (by mail, fax, or hand deliver) the completed form prior to the appointment. We cannot accept assignment for the cost of the visit without the proper authorization.

Co-payments are due at the time of the appointment. Please call if you do not know the amount due.

Medication.

Please bring a copy of any current prescriptions with your initial visit. Make sure you allow at least one *week* for a renewal of any prescription we issue to you. Prescriptions may also require a return visit before renewal.

Tests.

BRING

You may be asked to have other medical tests done at nearby facilities. ~~Unless specified, those tests are not covered by any agreement you have with our office.~~

REGISTRATION

(PLEASE PRINT)

Dr. Steven Gillon
401 South Van Brunt Street Suite 400
Englewood NJ 07631
Office: (201)-569-0555 Fax: (201)-569-3111

Date _____

E-Mail Address _____

Cell Ph # _____

Patient: _____ _____ _____ Home Ph # _____
Last Name First Name Initial

Street Address _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Single ☐ Married ☐ Seperated ☐ Divorced

Patient Employed by _____

Business Address _____

Occupation _____ Business Phone _____

Spouse(or responsible party) Name _____ Birthdate _____

Business Address _____

Occupation _____ Business Phone _____

Who is reponsible for this account? _____ Relationship to Patient _____

Social Security # _____ Spouse's Social Security # _____

Do You Have Medical Insurance? ☐ YES ☐ NO IF YES,

Name of Primary Insurer. _____

Contact # _____ Group # _____ Subscriber # _____

Name of Secondary Insurer.(if any) _____

Contact # _____ Group # _____ Subscriber # _____

☐ Medicare ☐ Medicaid Claim ID # _____

In case of emergency who should be notified? _____ Phone # _____

How did you learn of our practice? _____

ASSIGNMENT AND RELEASE

I The undersigned, have insurance coverage with _____
Name of Insurance Company

and assign directly to DR. _____ all medical benefits, If any, otherwise payable to me for services rendered.
I understand that I am financially responsible for all charges whether or not paid by Insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____
Signature of Insured/Guardian Date

MEDICARE AUTHORIZATION

I REQUEST THAT PAYMENT OF AUTHORIZED Medicare benefits be made either to me or on my behalf to DR. _____
for any services furnished me by that physician. I authorize any holder of medical information about me to release to Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____
Beneficiary Signature Date

Steven D. Gillon, DO **Internal Medicine, Gastroenterology**

How were you referred to us?_____ Date:_____DOB_____Age_____

Patient Name:_____

Chief Complaint_____

_____

_____

D/C-4+

Location_____
where is the pain/problem

Quality_____
sharp, dull, burning etc.

Severity_____
how severe is the pain on a scale of 1-5

Duration_____
seconds, minutes, hours etc.

Timing_____
Hour, day week etc.

Context_____
where were you when it began

Associated signs/symptoms_____

_____

_____

Modifying factors_____

_____

what makes it worse or better_____

Medical History:

Patient medical history:

Diabetes	Y	N
Hypertension	Y	N
Cancer	Y	N
Stroke	Y	N
Heart Trouble	Y	N
Arthritis/gout	Y	N
Colon polyps	Y	N
Bleeding	Y	N
Acute infections	Y	N
Cholesterol	Y	N
Arrhythmia	Y	N

other_____

_____

_____

D-1/3 C-2 to 3/3

Previous Hospitalizations/Surgeries/ Injuries When?

_____

_____

_____

_____

Medications:	dosage	frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies_____

Patient Social History:

Marital status: S M D W Children: 1 2 3 4 5 6

Use of Alcohol: Never Rarely Moderate: Daily: Caffeine?_____

Tobacco: Never Previously, but quit_____ Current packs/day_____

Excessive exposure: fumes dust solvents particles sun noise Use of drugs?_____

Exercise:_____ Occupation:_____

Family medical history: father_____ mother_____

Alive, deceased, age? siblings_____ children_____

PATIENT MEDICAL HISTORY

Date_____

REVIEW OF SYSTEMS: *Please indicate any personal history below(must complete)*

CONSTITUTIONAL SYMPTOMS
Good general health lately
Recent weight change
Fever
Fatigue
Headaches

EYES
Eye disease or injury
Corrective lenses
Blurred/double vision
Glaucoma

EARS/NOSE/MOUTH/THROAT
Hearing loss or ringing
Earaches or drainage
Chronic sinus problems or rhinitis
Nose bleeds
Mouth sores
Bleeding gums
Bad breath or taste
Sore throat or voice change
Swollen glands in neck

CARDIOVASCULAR
Heart trouble, angioplasty, bypass
Chest pain or angina pectoris
Palpitations or arrhythmia
Shortness of breath walking or lying flat
Swelling of feet or ankles

GASTROINTESTINAL
Loss of appetite
Change in bowel movements
Nausea or vomiting, heartburn
Diarrhea, bloating or belching
Painful bowel movements/constipation
Rectal bleeding or blood in the stool
Abdominal pain, Peptic ulcer, Reflux
Hepatitis, liver diseases

GENITOURINARY
Frequent urination or nighttime urination
Burning/painful urination
Blood in urine
Change in force of stream
Incontinence
Kidney stones
Erectile dysfunction
Testicular pain
Pain with menses
Irregular periods
Vaginal discharge
pregnancies
date last pap smear

RESPIRATORY
Chronic cough
Spitting up blood
Shortness of breath, asthma, wheezing

MUSCULOSKELETAL
Joint pain, stiffness or swelling
Weakness of muscles or joints
Muscle pain or cramps
Back pain or disc disease
Cold extremities
Difficulty walking

INTEGUMENTARY
Rash or itching
Change in skin color
Change in hair or nails
Varicose veins
Breast pain, lumps, or discharge

NEUROLOGICAL
Frequent or recurring headaches
Lightheaded or dizzy
Convulsions or seizures
Numbness or tingling sensations
Tremors, paralysis, stroke, head injury

PSYCHIATRIC
Memory loss, confusion
Loss of interests, depression
Loss of appetite, anxiety
Insomnia

ENDOCRINE
Glandular/hormone problem
Thyroid disease
Diabetes
Excessive thirst or urination
Heat or cold intolerance
Change in hat or glove size

HEMATOLOGIC/LYMPHATIC
Prolonged healing, bleeding, bruising
Anemia
Phlebitis
Blood transfusion
Enlarged organs or glands

ALLERGIC/IMMUNOLOGIC
Allergic to _____
Type of reaction_____
Food allergies
Environmental allergies

Other Charges.

In order to control costs for everyone, those patients who do not honor their commitment to pay will be charged for the added cost of collections. By signing the authorization, I agree to pay for services on time and to pay the added charges as follows.

- In case of missed appointments- $25.00
- In case of a late payment- a finance charge of $10.00 or 1.5% per month interest, which ever is greater.
- If a check used to pay my account is returned- the amount of the check plus a $25.00 fee will be charged.
- If the insurance information is not accurate- the amount due for services rendered.
- If you default on payment of the amount due- the costs of collections, including agency fees, any legal fees, and court costs.

You are welcome to pay by credit card for the co-payment or to set up a payment plan with regular credit card payments.

DIGESTIVE HEALTH CENTER OF ENGLEWOOD

STEVEN D. GILLON, D.O.

401 S. VAN BRUNT STREET SUITE # 400

ENGLEWOOD, NEW JERSEY 07631

Phone 201-569-0555 Fax 201-569-3111

PATIENT FINANCIAL RESPONSIBILITIES

PLEASE READ CAREFULLY

All insurance information must be correct, effective and up-to-date. Insurance verification is required and a copy of ALL insurance cards along with ONE FORM OF INDENTIFICATION must be made at the time of your visit. Medicare pays 80% of the approved figure. YOU are responsible for the 20% difference and YEARLY DEDUCTIBLES. If you have a secondary insurance it is forwarded automatically by Medicare.

All Managed Care Patients (HMO's PPO's) are responsible for acquiring completed referral forms PER VISIT from their Primary Care Physician. Failure to comply will result in denial of insurance claims and will be the responsibility of the patient for all charges incurred.

It is the responsibility of the patient to know and understand their particular policy and what they cover. If your policy requires a CO-PAY, payment must be made at the time of each service.

If the insured belongs to a health insurance carrier that requires PRECERTIFICATION prior to a surgical procedure, we must be advised. Failure to comply could result in denial or reduced payment of your insurance claims.

If applicable and necessary, payment arrangements are to be made prior to any surgical procedure or office visit.

If you have any questions, it would be to your advantage to contact your insurance carrier prior to any visit.

BY SIGNING BELOW, YOU ACKNOWLEDGE THAT YOU HAVE READ AND UNDERSTAND ALL OF THE ABOVE.

_____ _____

SIGNATURE OF PATIENT **DATE**