



DIGESTIVE HEALTH

PHYSICIANS

CONSULTATIVE GASTROENTEROLOGY ♦ GASTROINTESTINAL ENDOSCOPY ♦ HEPATOLOGY

JAMES W. PENUEL, MD

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JUAN G. HERRERA, MD

PAUL L. YUDELMAN, MD

ANDREE A. DADRAT, MD

RICHARD ORNATO, PAC

About Our Practice

www.digestivehealth.com

Digestive Health Physicians is dedicated to providing high quality medical care incorporating the latest advances in our specialty. We have physicians' board certified in Internal Medicine, Gastroenterology and Geriatrics. Our office staff is trained to provide excellent, courteous, personal care for our patients. We specialize in the diagnosis and treatment of digestive and liver diseases. This includes a wide range of problems such as swallowing disorders, heartburn, hepatitis, ulcers, abdominal pain, weight loss, diarrhea, colitis, constipation, jaundice, internal bleeding, colon polyps and cancer of the digestive tract. As consultants, we are often asked to assist in the management of difficult, complex cases with other physicians.

Gastrointestinal endoscopy (literally "to look within") is the specialized procedure we use to examine the upper gastrointestinal tract, colon, pancreas, liver and biliary tree. Should an endoscopy be needed, your physician will utilize delicate fiber optic video instruments, which enable us to accurately diagnose a wide variety of conditions affecting the digestive organs. In many cases, these procedures eliminate the need for major surgery. The procedure is most often performed as an outpatient using mild sedation.

We also perform highly specialized procedures such as ERCP for diagnosis and treatment disorders of the pancreas and bile ducts. Laser therapy is available for treatment of cancer and certain other conditions. Nonsurgical hemorrhoid treatments can be performed in our office. Within our practice we are happy to announce specialization in the art and science of liver disease. Some of our physicians have a special interest and years of experience in the management of challenging problems with hepatitis C, inherited liver diseases, management of cirrhosis and its complications. These physicians work closely with others around the country to provide up to date treatment options. We believe that liver disease requires specialized care and are pleased to announce the formation of a clinic dedicated exclusively to the need of patients who have this problem.

Registration- On the day of your appointment you must bring with you a **photo ID**, and your **insurance cards**. Bring all the paperwork you received in the mail from us completely filled out. If you do not have a photo ID you must bring a copy of a utility bill with your current address, and another form of ID. For your protection we must verify and protect your identity. You must also be prepared to pay any amount due before you see the physician or you may be asked to reschedule your appointment.

Appointment Cancellation - As a courtesy to our other patients, we request cancellations or changes in scheduling be made at least 24 hours in advance. If you do not call to cancel your appointment 24 hours prior a \$20.00 no show charge will be incurred. Please call (239)-939-9939, Option #3.

Prescription Refills - Please plan ahead and call for refills during regular office hours. We will have your prescriptions called in within 48 hours. Please call (239)-939-9939, Option #6. Medications cannot always be prescribed for a problem that has not been previously evaluated or if you have not been seen during the previous year. Controlled substances such as narcotics and tranquilizers will not be refilled at night or on weekends.

Insurance Questions - If you have questions or problems with your bill, insurance claims, or authorizations please call (239)-939-9939, Option #1.

Updated June 29, 2009

Main Office

7152 Coca Sabal Lane, Fort Myers, FL 33908
(239) 939-9939 FAX: (239) 931-5060

Bonita Springs

3501 Health Center Blvd., Suite 2410, Bonita Springs, FL 34135
(239) 947-2244 FAX: (239) 947-6358

www.digestivehealth.com

**Acknowledgment of Receipt of
Notice of Privacy Policy**

I hereby acknowledge that I was offered to read or take with me a copy of the Privacy Policy issued by Digestive Health Physicians PL, on the date indicated below.

Signature

Date

If you are not the patient, please state relationship:

- | | |
|--|---|
| <input type="checkbox"/> Parent (s) | <input type="checkbox"/> Legal Guardian |
| <input type="checkbox"/> Son or Daughter | <input type="checkbox"/> Facility Caretaker |
| <input type="checkbox"/> Other _____ | |

I understand that Digestive Health Physicians PL will call my home to remind me of my office appointments and procedures by an automated phone system. All other tests results or concerns someone will personally call me. To respect my privacy see choices below:

Home Phone

- You may leave a message with the following person(s) if I am not available:
- You may leave DETAILED Information on my answering machine.
- You may leave your NAME and PHONE NUMBER ONLY and I will return your call.

Work Phone

- You may call my work place.
- You may leave DETAILED INFORMATION on my answering machine.
- You may leave NAME AND PHONE NUMBER ONLY on my answering machine and I will return your call.
- You may NOT call my work place.

Please list below spouses, family, friends, caretakers, etc... that WE may communicate with in regards to your personal medical and financial information. This will include but not limited to: test results, appointment dates and time, billing information. Only the names that are listed below will be able to receive your information. Do not include your physicians on this list.

Unless you notify us in writing stating otherwise the above person(s) will always be able to receive information about you.

Patient's Signature _____ Date _____

Name _____ MR# _____

DOB _____



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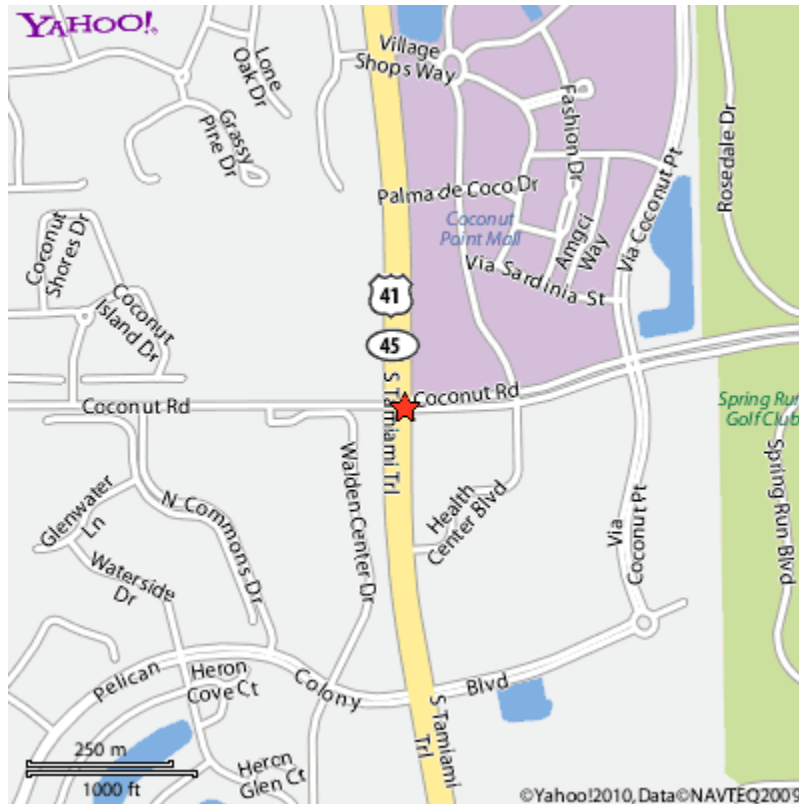
Dear _____

Thank-you for choosing our practice to assist in your healthcare needs. We appreciate the confidence you and your personal physician have placed in us. Your appointment has been scheduled for you on _____ in our Bonita Springs office.

Bonita Springs Office
Bonita Community Health Center
3501 Health Center Blvd., Suite 2410
Bonita Springs, FL. 34135

From Fort Myers: Travel south on U.S. 41, through 2 lights past Corkscrew road is Coconut Point, go thru the traffic light at Coconut Point. Stay in Left hand lane turn left immediately after Coconut Point into the Brooks Grand Plaza. You can also turn at the traffic light on Coconut Point and the make the first right onto the back parking lot of the center.

Heading North on U.S. 41: Travel on US 41 N, stay in Right hand lane. Go past the Ship Restaurant; turn Right into the Brooks Grand Plaza.



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Digestive Health Physicians Financial Policy

Welcome, we are so pleased you have selected our facility for your healthcare needs.

Below, we have answered a variety of commonly-asked financial policy questions. If you need further information about any of these policies, please ask us, we will be happy to assist you.

What Is My Financial Responsibility for Services?

Your financial responsibility depends on a variety of factors, explained below.

If You Have...	You Are Responsible For...	Our Staff Will...
Commercial Insurance Also known as indemnity, "regular" insurance, or "80%/20% coverage."	Payment of the patient responsibility for all office visits, injections, and other charges is expected from you at the time of the office visit.	Call your insurance company ahead of time to determine deductibles and coinsurance. File an insurance claim on your behalf.
HMO & PPO plans with which we have a contract	<u>If the services you receive are covered by the plan:</u> All applicable co-pays and deductibles are expected at the time of the office visit. <u>If the services you receive are not covered by the plan:</u> Payment in full is requested at the time of the visit.	Call your insurance company ahead of time to determine co-pays, deductibles, and non-covered services for you. File an insurance claim on your behalf.
HMO with which we are <u>not</u> contracted.	Payment in full for office visits, injections, and other charges at the time of office visit.	File an insurance claim as a courtesy to you.
Point of Service Plan or Out Of Network PPO	Payment of the patient responsibility—deductible, co-pay, non-covered services—at the time of the visit.	Call your insurance company ahead of time to determine out of network benefits, co-pays, deductibles, and non-covered services. File an insurance claim as a courtesy to you.
Medicare	If you have <u>Regular Medicare</u> , and have not met your \$135 deductible, we ask that it be paid at the time of service. Any services not covered by Medicare are requested at the time of the visit. <u>If you have Regular Medicare as primary, and also have secondary insurance or Medigap:</u> No payment is necessary at the time of the visit. <u>If you have Regular Medicare as primary, but no secondary insurance:</u> Payment of your 20% co-pay is requested at the time of the visit.	File the claim on your behalf, as well as any claims to your secondary insurance.

Medicare HMO	All applicable co-pays and deductibles at the time of the office visit.	File the claim on your behalf, as well as any claims to your secondary insurance.
No Insurance	Payment in full at the time of the visit.	Work with you to settle your account. Please ask to speak with our staff if you need assistance.

- I understand that it is my responsibility to provide the office of Digestive Health Physicians with current, accurate billing information at the time of check in and to notify Digestive Health Physicians of any changes in this information.
- I understand that it is my responsibility to know my specialist co-pay (which can be different than my Primary Care co-payment) and to pay it at the time of service. I understand that this is a contractual agreement that I have with my health plan and that Digestive Health Physicians also has a contractual agreement with my health plan to collect co-pays at the time of service, and they are required to report to the carrier any enrollees failing to pay the co-pay.
- I understand that if I present an insufficient funds check (NSF check) for payment on my account that I will be charged a \$25 NSF fee. I further understand that to rectify my account, I will be required to pay with cash, a money order, cashier's check, or credit card.
- If I do not show up for a scheduled appointment and did not cancel within 24 business hours I will be charged \$20.00 for each appointment I miss.
- I understand that there is a \$20 fee to complete disability paperwork associated with my care. I will be provided a standard form free of charge; however if additional disability forms (such as FMLA) require completion, I understand that the \$20 fee (payable prior to completion) is required.
- I understand that Digestive Health Physicians will verify my insurance eligibility, deductible amounts, and coinsurance amounts prior to any outpatient procedures that I may have. I further understand that it is the policy to collect the deductible and/or coinsurance prior to my procedure with Digestive Health Physicians. I further understand that THE FEE I AM QUOTED IS AN ESTIMATE based on 1) anticipated procedure to be performed and 2) current information provided to Digestive Health Physicians by my insurance carrier.
- I understand that I will be billed for any amounts due by me (co-payments/coinsurance amounts/ deductibles) and that I have a financial responsibility to pay these amounts. I understand that I will be provided with two (2) statements for any balance due after insurance payment. I further understand that if I have not made payment prior to the second statement being mailed, that the second statement will be marked as "Final Notice" and may be sent to an outside collection service if I do not fulfill my financial obligations. I also understand that I will be responsible for any collection, interest or legal expenses associated with the collection efforts.
- I understand that the Digestive Health Physicians will obtain the necessary prior authorizations prior to rendering treatment. I further understand that prior authorization is not a guarantee of payment, and that I am responsible for any bills not paid by my insurance carrier.
- I understand that Digestive Health Physicians may also take a verbal request to use my credit card for payment on my account.

I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable co-payments and deductibles, are my responsibility.

I authorize my insurance benefits be paid directly to Digestive Health Physicians.

I authorize Digestive Health Physicians to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

Date

Signature

Printed Name

Digestive Health Physicians Patient Registration

Patient's Name: _____ SS #: _____

First Name MI Last Name

Date of Birth: _____ __Male __Female __Single __Married __Widowed __Divorced __Separated

Local Address : _____

City/State/Zip Code: _____ Home Phone w/Area Code: _____

Cell Phone w/Area Code: _____ Fax w/Area Code: _____

Spouse's Name: _____ SS #: _____

Spouse's Employer: _____ Spouse's Work Phone #: _____

Patient's Employer: _____ Work Phone w/Area Code: _____

Responsible Party: _____ Relationship: __Self __Spouse __Parent __Other: _____

In case of emergency, contact (not living with you): _____

Phone Number w/Area Code: _____ Relationship to Patient: _____

Referring Physician's Name & Phone Number: _____

You must bring with you on the day of your visit a photo ID with your current address listed on the ID and a copy of your primary and secondary insurance cards.

If you do not have a photo ID with your current address you must bring with you a copy of any utility bill and another form of identification. We will accept a social security card, a passport, any school ID, a voter's registration card, or any membership card for example: Sam's, Costo, ect.

For your protection and privacy we must verify your identity we can only do this by you providing us with the requested information. Thank you for your understanding.

Are you a full time resident? _____ No _____ Yes

Northern Address: _____

City/State/Zip Code: _____ Home Phone w/Area Code: _____

Insurance Company # 1: _____ Phone Number: _____

Primary Insured's Name: _____ Date of Birth: _____

Policy #: _____ Group #: _____ Relationship: _____

Insurance Company # 2: _____ Phone Number: _____

Primary Insured's Name: _____ Date of Birth: _____

Policy #: _____ Group #: _____ Relationship: _____

Patient's OR Insured's Signature (If patient is a Minor, must have Responsible Party Signature)

Date

MR Number

Patient Health History

This form must be completed at each visit adding and updating the appropriate information

Date _____ Referred By: _____

Age _____ Ht _____ Wt _____ What is your occupation or former occupation? _____

Reason for Visit _____

Medical Illnesses

Surgery/Operations

Current Medications: (Include over the counter medications and vitamins)

Allergies: Please list any medications or other substances to which you are allergic and the type of reaction:

None Known

Latex Allergy No Yes Are you taking aspirin or blood thinners (Coumadin/Plavix)? Yes No

Review of Systems:		No	Yes			No	Yes
Constitutional	Unintended Weight Gain/Loss	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal	Nausea/Vomiting	<input type="checkbox"/>	<input type="checkbox"/>
	Eyes	Change in vision	<input type="checkbox"/>		<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>
ENT	Loss of hearing	<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal	Rectal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
	Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>		Joint pain	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular	Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	Integumentary	Back pain	<input type="checkbox"/>	<input type="checkbox"/>
	Swelling of legs/ankles	<input type="checkbox"/>	<input type="checkbox"/>		Skin rash	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory	Calf cramps while walking	<input type="checkbox"/>	<input type="checkbox"/>	Heme/Lymphatic	Enlarged lymph nodes	<input type="checkbox"/>	<input type="checkbox"/>
	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>		Easy bruising	<input type="checkbox"/>	<input type="checkbox"/>
				Neurologic	Numbness of arms/legs	<input type="checkbox"/>	<input type="checkbox"/>

Social/Family History:

Married Single Widow(er) Divorced

Sex: M F

Smoker No Yes How Much _____

Do you Drink? No Yes > 7 drinks per week > 3 per occasion > 65 yrs old -women

> 14 drinks per week > 4 per occasion ≤ 65 yrs old-men

Colonoscopy? Yes When? _____ No

Family History of Colon Cancer? No Yes When? _____ Who? _____

Family History: Major Illnesses or cause of death

Current Age

Age at death

How old at diagnosis? _____

Father _____

Mother _____

Brothers _____

Sisters _____

NAME _____ DOB _____ CHART# _____