LM PRASAD MD SC
Colon and Rectal Surgery

PATIENT DEMOGRAPHIC AND HISTORY

PATIENT INFORMATION **(Please Print)** **Today's Date: ___/___/___**

Name: _____

Mailing Address: _____ City/State/Zip_____

Home phone _____ Work Phone _____Cell Phone _____

Ok to leave message: ☐ **yes** ☐ **No** **Ok to leave message:** ☐ **yes** ☐ **No** **Ok to leave message:** ☐ **yes** ☐ **No**

Date of Birth: ___/___/___ SSN____-____-_____ Marital Status: _____ Age:_____ Sex:_____

INSURANCE INFORMATION

Primary Insurance Co. Name_____

Responsible Party: ☐ Self ☐ Spouse ☐ Parent

Name of Insured_____

Address of Insured (if different)_____

_____

Date of Birth of Insured_____

Employer Name_____

Relationship of patient to Insured_____

Secondary insurance Co. Name_____

Responsible Party: ☐ Self ☐ Spouse ☐ Parent

Name of Insured_____

Address of Insured (if different)_____

_____

Date of Birth of Insured_____

Employer Name _____

Relationship of patient Insured_____

Emergency Contact _____ **Relationship**_____ **Phone**_____

Can we discuss your medical conditions with other members of your family household? ☐ Yes ☐ No Specify_____

Primary Physician_____ **Referring Physician** _____

Phone #: _____ **Phone #**: _____

Race:

☐White ☐American Indian or Alaska Native ☐Asian ☐Black or African American ☐Other Race:_____

Ethnic Group:

☐Hispanic or Latino ☐Not Hispanic or Latino ☐Unknown

Pharmacy:

Name: _____ Address/Phone #:_____

I authorize the release of medical information to my primary care or referring physician, to consultants if needed, and as necessary to process insurance claims, insurance applications, and prescriptions. I also authorize payment of medical benefits to the physician.

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered unless you are in an insurance plan in which we participate. For those patients, applicable copayments will be collected. **We accept payment in the form of cash or credit card.** If we do accept a check for payment, and the check does not clear the bank, a $25.00 service fee will be automatically added to your account. **Please note that any procedure performed in the office may be billed separately and in addition to the office visit fee.**

Your signature below signifies your understand and willingness to comply with this policy.

Patient or Responsible Party Signature_____ Date_____/_____/_____

LM PRASAD MD SC
Colon and Rectal Surgery

HISTORY (PAGE 1 OF 4 – *PATIENT TO COMPLETE*)

Date: _____

Chief complaint:_____

How long have you had this complaint?_____

Are you having any rectal bleeding?	Yes	No
If yes, is the bleeding bright red or dark red?	Bright red	Dark red
If yes, is the blood mixed with the stool or not mixed with the stool?	Mixed	Not mixed
Do you have any blood on the toilet paper?	Yes	No
Do you have blood in the toilet water?	Yes	No
Do you feel your rectum is falling out of your anus?	Yes	No
If yes, does the rectum go back in spontaneously?	Yes	No
If yes, do you ever have to push the rectum back in manually?	Yes	No
If yes, have you ever been unable to push the rectum back in?	Yes	No
Do you have severe pain around the anus?	Yes	No
Do you feel a ripping at the anus with bowel movements?	Yes	No
Do you have itching/burning at the anus?	Yes	No
Did you ever have anal warts?	Yes	No
Do you have drainage from the anus?	Yes	No
Are you incontinent to solid stool?	Yes	No
Are you incontinent to liquid stool?	Yes	No
Are you incontinent to gas?	Yes	No
In mothers, did you have birthing trauma that required stitches?	Yes	No
Do you have abdominal pain or cramps?	Yes	No
If yes, what is the location?_____		
Has anyone in your family had colon cancer at age less than 50?	Yes	No
Has anyone in your family had colon polyps?	Yes	No
Has anyone in your family had more than 10 colon polyps?	Yes	No
Do you need antibiotics prior to dental procedures?	Yes	No

Age _____ Height _____ Weight_____
Date of birth _____ Sex _____ M _____ F

LM PRASAD MD SC
Colon and Rectal Surgery

HISTORY (PAGE 2 OF 4 – *PATIENT TO COMPLETE*)

Past Medical History (place an X in the box next to your associated medical conditions)

☐ Diabetes	☐ High cholesterol	☐ Crohn's disease
☐ Asthma	☐ High blood pressure	☐ Ulcerative Colitis
☐ Emphysema	☐ Irritable bowel	☐ Colon polyps
☐ Arthritis	☐ Stomach ulcer	☐ Colon cancer
☐ Migraines	☐ Kidney stones	☐ Breast cancer
☐ Anxiety	☐ Enlarged prostate	☐ Uterine cancer
☐ Depression	☐ Abnormal heart rhythm	☐ HIV
☐ Hepatitis	☐ Heart valve damage	☐ Prostate cancer
☐ Diverticulosis	☐ Heart murmur	☐ Glaucoma
☐ Fibromyalgia	☐ Heart attack	☐ Stroke
☐ Liver disease	☐ Anemia	☐ Blood clots
☐ Rheumatic Fever	☐ Chronic back pain	☐ Kidney disease

Other _____

Previous Surgeries_____

_____

_____

Medications (please include name, dose, and when taken)

_____ _____

_____ _____

_____ _____

_____ _____

Any Allergies? (List the medication or substance *and* your reaction. Include seasonal and food allergies)

_____

_____

_____

Are you taking Aspirin?	Yes	No	Are you taking Plavix?	Yes	No
Are you allergic to latex?	Yes	No	Are you allergic to peanuts?	Yes	No
Are you allergic to IV dye?	Yes	No	Are you allergic to shellfish?	Yes	No

Social History

Do you smoke?	Yes	No	Do you drink alcohol?	Yes	No
How many years?	_____		daily?	Yes	No
How many packs per day?	_____				

John Park MD, Slawomir Marecik MD, Kunal Kochar MD
1550 N. Northwest Highway, Suite 107
Park Ridge, IL. 60068

Patient Name

LM PRASAD MD SC
Colon and Rectal Surgery

HISTORY (PAGE 3 OF 4 – *PATIENT TO COMPLETE*)

Family History (please specify which family member had any of the following conditions)

Colon polyps_____ Colon cancer_____
Ulcerative colitis_____ Crohn's disease_____
Familial polyposis_____ Breast cancer_____
Uterine cancer_____ Diabetes_____
Heart disease_____ Strokes_____

Review of Systems

Eyes:

Have your eyes turned yellow?	Yes	No	Do you have glaucoma?	Yes	No

Head, ears, nose, throat and neck:

Do you have loose teeth?	Yes	No	Any frequent nose bleeds?	Yes	No
Any chronic sinus problems?	Yes	No	Do you have sleep apnea?	Yes	No

Cardiac:

Do your legs ever swell up?	Yes	No	Does your heart ever flutter?	Yes	No
Do you have chest pain?	Yes	No	Do you ever get light-headed?	Yes	No

Lungs:

Do you get short of breath?	Yes	No	Do you have a chronic cough?	Yes	No

Gastrointestinal:

Have you been nauseated recently?	Yes	No	Are you constipated?	Yes	No
Have you been vomiting recently?	Yes	No	Have you been having diarrhea recently?	Yes	No

Genitourinary:

Do you urinate often during the night?	Yes	No	Do you have blood in the urine?	Yes	No
Do you get urinary infections?	Yes	No	Any pain/burning when you urinate?	Yes	No

Neurologic:

Do you have headaches?	Yes	No	Are you sensitive to light?	Yes	No
Any recent slurring of your speech?	Yes	No	Have you ever been temporarily blind?	Yes	No

Integuments:

Any skin ulcers?	Yes	No	Any breast pain or masses?	Yes	No
Dry skin?	Yes	No	Any unusual rashes?	Yes	No

Psychiatric:

Feeling down?	Yes	No	Hearing voices?	Yes	No	Trouble concentrating?	Yes	No

Endocrine:

Gaining weight?	Yes	No	Losing weight (not intentional)?	Yes	No

Hematologic:

Bleeding problems?	Yes	No	Prior blood clots?	Yes	No	Sickle cell disease?	Yes	No

Musculoskeletal:

Difficulty walking?	Yes	No	Do your joints hurt?	Yes	No

Have you had any of the following tests? (If yes give the approximate date.)

Flexible sigmoidoscopy Yes No Date: _____ Colonoscopy Yes No Date: _____

If yes, by whom?_____ If yes, by whom?_____

Barium enema Yes No Date: _____ Cat scan of the abdomen Yes No Date: _____

LM PRASAD MD SC
Colon and Rectal Surgery

John J. Park M.D.
Slawomir J. Marecik, M.D.
Kunal Kochar, M.D.
1550 N. Northwest Hwy, Suite 107
Park Ridge, IL 60068

Office Policies

1. It is the patient's responsibility to check to see if we are in-network.
2. If you have HMO insurance you are responsible for your referrals. Referrals are only valid for 90 days from the issue date and are only good for as many visits as your primary doctor has approved.
3. You are responsible for knowing the policies of your insurance, such as co-pay, coinsurance, deductible, pre-existing conditions, policy exclusions, effective date, termination, etc.
4. Co-pays and self-pay procedures are due at the time of service, no exceptions.
5. Each scheduled appointment in our office is considered an office visit and will be charged to your insurance.
6. If a procedure is performed, it is an additional charge to your insurance.
7. If my account is referred to a collection agency, I will be responsible for all collection fees which is 30% of the unpaid balance and reasonable attorney fees of one third (1/3) of the balance referred to the attorney.
8. If you are scheduled for a procedure it is your responsibility to make an appointment with your primary doctor for medical clearance. You are responsible to obtain your bowel prep and start it as instructed.

_____ _____
Patient Signature Date

_____
Patient Name

LM PRASAD MD SC
Colon and Rectal Surgery

Privacy Policy Acknowledgement Form

The Notice of Privacy Practice for the office of LM PRASAD M.D.,S.C. is available for your review at the front desk and on our website at http://www.chicagocolorectal.com. Should you wish to receive your own copy to take with you please ask our receptionist. The Notice of Privacy Practices may change from time to time and you are welcome to request a revised copy at your next visit, call our office and request a copy, or mail a written request.

Section 1- Acknowledgement

I acknowledge and understand the Notice of Privacy Practices for the office of LM Prasad MD SC.

_____ _____
Patient Name Date

_____ _____
Date of Birth MRN **(Office use)**

Section 2- Notification and Emergency Designee

I give permission to LM PRASAD M.D.,S.C. and staff to perform the following duties in an effort to maintain continuity of care.

Confirm/revise my appointment times by calling by home, business, and any other designated phone number

☐YES ☐NO

Leave message of normal test results on my home answering machine or with a specified family member

☐YES ☐NO

The office and personnel are authorized to contact the party listed below to discuss and handle my medical care in the event of an emergency or to receive message information on my appointment and test results:

_____

Designated Person Contact Number

Section 3- Patient Portal

This is the newest feature of your Electronic Health Records. We are excited to introduce the latest technology in patient communications. The Portal is completely secure and HIPPA compliant to ensure the safety of your Personal Health Information. When you are "web enabled" with LM PRASAD M.D.,S.C. you will be able to do the following via web:

1. Update your address, phone numbers, email address, employer, pharmacy and emergency information.
2. Enter or update your medical, surgical, and hospitalization histories as well as your allergy information.
3. Receive email reminders of existing appointments, confirmations of new appointments as well as notifications of new information posted to the web portal.
4. View your current and previous patient statement.
5. View your current and previous appointments.

Once you give us your email address, we can set up your web id and password. Then we can start using this great new method of communication!

☐YES ☐NO If yes please provide your email address_____

I understand the information provided to me in the privacy notice and I have indicated my response to the questions in each section

_____ _____
Patient (or Guardian) Signature and Phone Number Date

LM PRASAD MD SC
Colon and Rectal Surgery

Colonoscopy Surgical Coding Guidelines

Screening Colonoscopy – Average Risk – Procedure Code G0105 only, Diagnosis Code V76.51 only

A screening colonoscopy is for average risk patients and is covered once every 10 years. A patient must meet the following criteria to be considered for a screening colonoscopy:

• Adults 50 years or older

• Patients are asymptomatic (no present signs or symptoms)

• Patients have no personal history of polyps or colorectal cancer

• Patient has not had a colonoscopy in the last 10 years

NOTE: If you have a preventative policy under your insurance plan the above criteria will apply to your procedure.

Colonoscopy - High Risk

A colonoscopy may be recommended by your physician every 2-5 years for the following high risk patients:

• A personal history of colon polyps

• A personal history of colorectal cancer

• A personal history of inflammatory bowel disease, including Crohn's Disease and Ulcerative Colitis

• A close relative (sibling, parent, or child) who has had colorectal cancer or an adenomatous polyp (a type of polyp that could become cancerous)

• A family history of familial adenomatous polyposis (this involves multiple adenomatous polyps, often in the hundreds, and carries a very high risk of colon cancer)

• A family history of hereditary non polyposis colorectal cancer (a type of colorectal cancer that runs in families and tends to cause cancer at a relatively young age - under 45 years)

NOTE: A high risk colonoscopy is typically covered under your preventative plan.

Diagnostic Colonoscopy

A diagnostic colonoscopy may be recommended for the following signs and symptoms:

• Blood in stool/hem positive stool

• Rectal bleeding

• Iron deficiency anemia of unknown cause, confirmed by laboratory findings

• Change in bowel habits

• Persistent abdominal pain

NOTE: A diagnostic colonoscopy will apply to your deductible and co-insurance.

Financial Responsibility

Most insurance companies offer preventative services and you can contact your insurance company if you have any questions (procedure codes are typically 45378, 45383 or 45385). It is the patient's responsibility to know and understand their coverage and benefits. Please be aware that if you have a personal history of colon polyps/colorectal cancer or family history of colorectal cancer, this is usually covered as a diagnostic colonoscopy and your deductible and co-insurance apply. LM Prasad MD SC, Colon and Rectal Surgery obtains prior authorization for services that require authorization, but we cannot guarantee how it will be covered.

Colonoscopy will create claims from several sources: you will receive bills/EOBs (Explanation of Benefits) for the physician performing the procedure, the facility where it was performed, anesthesia and pathology, if applicable.

It is the patient's responsibility to notify our office of any insurance changes prior to your scheduled procedure or your claim may be denied, making you financially responsible for the entire balance. Please be advised that LM Prasad MD SC, Colon and Rectal Surgery is not responsible for paying your deductible or co-insurance, therefore we DO NOT offer a discount after we receive payment from your insurance company.

Date: _____ Patient Name: _____.

Patient Signature: _____.