Windham GI, LLC

Phone: 860-423-3299 *Ajit Kokkat, MD* *Fax: 860-423-8739*

LAST NAME_____**FIRST NAME**_____**M.I.**_____ **SEX**_____

DATE OF BIRTH_____ **SOCIAL SECURITY #**_____ **E-MAIL**_____

ADDRESS_____**APT. #**_____ **CITY** _____**STATE**_____**ZIP CODE**_____

HOME PHONE (_____**)**_____**WORK PHONE (**_____**)**_____**EXT.** _____**CELL#**_____

LANGUAGE_____**RACE**_____ **ETHNICITY***: Hispanic or Latino*___ *Non-Hispanic or Latino*___ *Unknown*___ *Declined*_____

EMPLOYER_____ *FULL-TIME PART-TIME STUDENT* **MARITAL STATUS:** *Single Married Divorced Widowed*

PHARMACY: _____ **TOWN:** _____

WHO REFERRED YOU TO OUR PRACTICE?

REFERRING PHYSICIAN'S NAME_____ADDRESS_____

PRIMARY CARE PHYSICIAN'S NAME_____ADDRESS_____

WHAT IS YOUR HEALTH INSURANCE? PLEASE COMPLETE ALL INFORMATION BELOW

1. **PRIMARY INSURANCE**_____ 2**. SECONDARY INSURANCE**_____

ADDRESS_____ ADDRESS_____

INSURED'S NAME_____ INSURED'S NAME_____

SUBSCRIBER ID#_____ SUBSCRIBER ID#_____

SUBSCRIBER SS#_____ SUBSCRIBER SS#_____

SUBSCRIBER DATE OF BIRTH_____ SUBSCRIBER DATE OF BIRTH_____

GROUP#_____COPAY $_____ GROUP#_____COPAY $_____

RELATIONSHIP TO PT_____ RELATIONSHIP TO PT_____

WHO SHOULD WE CONTACT IN CASE OF EMERGENCY?

NAME_____***PHONE#***_____***RELATION TO PT***_____

Patient's or Authorized Signature: I UNDERSTAND THAT PAYMENT IS EXPECTED AT THE TIME OF MY VISIT. IF MY INSURANCE COVERAGE REQUIRES A REFERRAL IT IS MY RESPONSIBILITY TO OBTAIN THE REFERRAL FROM MY PCP. IF THE REFERRAL IS NOT PRESENT PRIOR TO/OR ON THE DAY OF MY VISIT I WILL BE HELD RESPONSIBLE PERSONALLY FOR CHARGES INCURRED. I HEREBY AUTHORIZE THE RELEASE OF ANY AND ALL MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR THE PARTY WHO ACCEPTS ASSIGNMENT. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE ABOVE SIGNED PHYSICIAN OR SUPPLIER OF SERVICES. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR SERVICES RENDERED BY WINDHAM GI, LLC.
I UNDERSTAND THAT MY SIGNATURE BELOW ALSO CONSTITUTES PERMISSION FOR THIS OFFICE TO SUBMIT TO MY INSURANCE AND UPON SIGNING THAT THE REIMBURSEMENT WILL BE FORWARDED TO THIS OFFICE.

MY SIGNATURE BELOW DENOTES THAT I HAVE AGREE TO THE ABOVE

PATIENTS SIGNATURE DATE

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Waiver
Disclosure/Agreement

Patient Name: _____ Date of Birth: _____

Reason for today's visit:

- ☐ Routine preventative exam…. I have no medical complaint or significant problem/abnormality that I am aware of
- ☐ Yes, my insurance covers Preventative Medical Services
- ☐ No, my insurance does not cover Preventative Medical Services
- ☐ I do not know if my insurance plan covers Preventative Medical Services

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- ☐ I do have a problem/complaint that I wish to have evaluated/ treated by the doctor

My chief complaint is: _____

I agree to pay for any and all medical services I receive from the doctors/providers of this practice that my insurance company refuses to pay, for whatever reason. This office will file a claim in my behalf, however, if my insurance company refuses to pay, for whatever reason (e.g. non-covered services, plan does not pay for preventative medicine visits or my failure to secure a referral from my primary care physician) I will pay for same upon written/verbal notice of their refusal. Failure to pay within 45 days of filing is, for the purpose of this agreement, a refusal to pay.
I further agree and understand that this office can only code and file a claim for my visit(s) with a diagnosis that was encountered in my medical record. Thus, this office cannot comply with any request to improperly alter the medical record or claim for the purpose of securing payment from any insurance carrier which may be considered fraudulent act(s).
In the event I do not pay for these or any other services provided me when due, I agree to pay all cost of collection, including reasonable attorney fee, whether or not a lawsuit is commenced as part of the collection process.

Signature: _____ Date: _____
Patient (or responsible part if minor)

Print Name: _____

Witness: _____

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Patient Name: _____ Date of Birth: _____

Chief complaint: _____

Pharmacy: _____ Primary Care Provider: _____

Have you ever had a colonoscopy? _____ If yes, When? _____ By who? _____

Please Check All That Apply

↓		↓		↓		↓	
	Decreased Physical Activity		Eye discharge		Cold intolerance		Environment allergies
	Loss of appetite		Eye Itching		Heat intolerance		Food Allergies
	Chills		Eye Pain		Excessive thirst		Immunocompromised
	Increased sweating		Eye Redness		Excessive hunger		Dizziness
	Feeling Tired		Eye pain w/sunlight		Excessive urination		Facial Changes
	Fever		Visual Disturbance		Difficulty urinating		Headaches
	Unexplained Weight Loss		Sleep apnea		Painful Urination		Light-headedness
	Nasal Congestion		Chest Tightness		Involuntary urination		Numbness
	Dental Issues		Choking		Flank Pain		Seizures
	Drooling		Cough		Frequent urination		Speech Difficulty
	Discharge from Ears		Shortness of breath		Genital sore		Loss of consciousness
	Ear Pain		Loud noise when breathing		Blood in urine		Tremors
	Facial Swelling		Wheezing		Penial discharge		Weakness
	Hearing loss		Chest Pain		Pain In Penis		Swollen lymph Glands
	Mouth sores		Leg Swelling		Scrotal swelling		Bruises/bleeds easily
	Nosebleeds		Palpitations		Testicular pain		Agitation
	Postnasal drip		Abdominal distention		Urgency		Behavior Problems
	Nasal Discharge		Abdominal Pain		Decreased Urination		Confusion
	Sinus Pressure		Anal Bleeding		Joint pain		Decreased concentration
	Sneezing		Blood in stool		Back pain		Sad
	Sore throat		Constipation		Gait problems		Hallucinations
	Ringing in ears		Diarrhea		Joint swelling		Hyperactive
	Trouble swallowing		Nausea		Muscle Pain		Nervous/anxious
	Voice change		Rectal Pain		Neck Pain		Sleep disturbance
			Vomiting		Neck stiffness		Suicidal Ideas
					Skin Color change		
					Pale		
					Rash		
					Wound		

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Patient Name:_____ D.O.B.: _____

Family History

Family Member	Disease/Illness
Father	
Mother	
Sister	
Brother	
Maternal Grandmother	
Maternal Grandfather	
Paternal Grandmother	
Paternal Grandfather	

Allergies

Medication Allergies	*Other Allergies*

Medical Problems	Surgical Procedures

Medications

Rx Name	*Dosage*

Smoking History		Alcohol Use	
Never a smoker		Never Drank	
Former Smoker	*Packs/day:____* *Age of start:___* *Age of Quit: ___*	***Less than 1 drink per week***	
Current Smoker:	*Packs/day: ____* *Age Started: ___*	***Alcohol Use***	*Per Week: _____* *Type: _____*

Drug History

	Former User	*Current User*
Cocaine		
Marijuana		
IV drugs		

☐ ***Methadone Program*** ☐ ***Subaxone Program***

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Payment Policy

Thank you for choosing us as your Gastroenterology care provider. We are committed to providing you with quality and affordable healthcare. Because some of our patients have questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign the space provided. A copy will be provided to you upon request.

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. **Co-payments.** All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. **Non-Covered Services.** Please be aware that some – perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. **Proof of Insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct information in a timely manner, you may be responsible for the balance of a claim.

5. **Claims Submission**. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

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6. **Coverage Changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. **Nonpayment.** If your account is over 60 days past due, you will receive a letter stating that you have 10 days to pay your account in full. Partial payment will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this occurs, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Patient Name (please PRINT) ***Date of Birth***

_____ _____

Signature of patient or responsible party ***Date***