

Saman B. Chubineh, M.D.
REGISTRATION FORM

Please answer all questions in full

Today's Date:		Primary Care Physician:			
PATIENT INFORMATION					
Patient's last name:		First:	Middle:	Salutation:	Marital status:
Is this your legal name?	If not, what is your legal name?		Birth date:	Age:	Sex:
Address:		City:		Zip code	
Home phone no.:		Cell phone no.:		E-mail Address:	
Social Security Number:		Ethnicity/Race		Preferred Language	
Please provide your pharmacy name and Location					
Occupation:			Referring Physician/How you came to our practice:		
IN CASE OF EMERGENCY					
Name of Emergency Contact:		Relationship to patient:		Home phone no.:	Work phone no.:
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Saman B. Chubineh, M.D. or insurance company to release any information required to process my claims.					
Patient/Guardian signature				Date	

Please answer all questions in full

Today's Date:

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name <i>(Last, First)</i> :	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-Binary	DOB:
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PERSONAL HEALTH HISTORY

List any medical problems that have been diagnosed and when you were diagnosed

Please list major surgeries

Type	Year	Type	Year

Other hospitalizations

Reason	Year

List your prescribed drugs and over-the-counter drugs, such as vitamins

Name	Strength	How often	Name	Strength	How often

Allergies to medications

Name of medication	Reaction You Had	Name of Medication	Reaction you had

HEALTH HABITS AND PERSONAL SAFETY

GI history	Please check here if you have ever seen a Gastroenterologist before. If so, who?		
	Have you ever had an upper endoscopy or colonoscopy before? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, when?		
	Does anyone in your family have a history of colon cancer or colon polyps? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, who and at what age?		
Alcohol	Do you drink alcohol?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, what kind?		
	How many drinks per week?		
	Are you concerned about the amount you drink?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you considered stopping?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Tobacco	Do you use tobacco or tobacco products?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Cigarettes/day?	# of years?	Year quit if applicable?
Drugs	Do you currently use recreational or street drugs?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever given yourself street drugs with a needle?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Sex	Are you sexually active?		<input type="checkbox"/> Yes <input type="checkbox"/> No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS
Father		
Mother		
Sibling	<input type="checkbox"/> M	
	<input type="checkbox"/> F	
	<input type="checkbox"/> M	
	<input type="checkbox"/> F	
	<input type="checkbox"/> M	

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

<input type="checkbox"/> Skin	<input type="checkbox"/> Chest/Heart	<input type="checkbox"/> Recent changes in:
<input type="checkbox"/> Head/Neck	<input type="checkbox"/> Back	<input type="checkbox"/> Weight
<input type="checkbox"/> Ears	<input type="checkbox"/> Intestinal	<input type="checkbox"/> Energy level
<input type="checkbox"/> Nose	<input type="checkbox"/> Bladder	<input type="checkbox"/> Ability to sleep
<input type="checkbox"/> Throat	<input type="checkbox"/> Bowel	<input type="checkbox"/> Other pain/discomfort:
<input type="checkbox"/> Lungs	<input type="checkbox"/> Circulation	



Saman B. Chubineh, M.D.

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Phone: 716-240-2296

Fax: 716-462-6000

Lockport

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Financial Policy

Thank you for choosing us as your healthcare provider. We are committed to providing you with the highest quality healthcare. We ask you to read and sign this form to acknowledge your understanding of our patient financial policies. Our practice will work with you to help fulfill your payment responsibility. Ultimately, you are responsible for any outstanding balance that is not covered by your health insurance. This includes co-pays, deductibles, and services not covered by your insurance. To avoid interruption of your healthcare, we require payment at the time of registration.

Co-Payments

Patients who do not pay their co-pay on the date of their service will incur an additional \$25 fee in addition to their co-pay.

Self Pay (no insurance) or Non-participating healthcare plans

If you are seeking treatment and do not have health insurance or are insured through a plan we do not participate with, you will be required to pre-pay an estimated amount which will range from \$100-\$200 for an initial office visit. Should you require procedures, you will be quoted a separate price that will also require payment prior to service. As these are estimates, you will either be billed for any remaining amount due or refunded for overpayment. It is ultimately your responsibility to check if we are participating providers with your health insurance plan.

Billing for colonoscopies:

A common question that arises is whether a scheduled colonoscopy will be billed as preventative (routine without digestive complaints), or diagnostic (to examine for a source of issues possibly related to the colon). As a general rule, patients aged 50-75, without bowel related disorders, rectal bleeding, weight loss, or abdominal pain, will be billed as preventative. Another way that the colonoscopy may be billed as preventative is if there is a family history of colon cancer or colon polyps, depending on the age of onset for that relative and how closely related you are. Therefore, ALL patients over the age of 75 that are not having a colonoscopy for surveillance (a history of polyps) or secondary to family history of polyps or colon cancer will be billed as diagnostic meaning you may receive a bill for this examination.

However, even if your exam is billed as preventative, you potentially may incur a charge. This would mainly be if polyps were noted and removed during your colonoscopy, your exam will most likely be a diagnostic test as there are finding, i.e., the polyps. Your insurance company will notice you went in for a screening and we will note that and with billing modifiers we will let them know that while during that preventative colonoscopy, polyps were found. This will change the amount you will owe towards your colonoscopy. Should you have questions regarding how your examination will be billed, it would be best to contact our office with your concerns, or contact your insurance company regarding what is covered under your plan.

Medication Refills

All medications are refilled in a timely manner upon request. If you have not been seen for 6 months or more, an office visit will be required

Testing

Testing may ultimately be required as part of your medical care. This would include laboratory work, radiology tests, or any other tests that may be required. It is ultimately your responsibility to check with your insurance provider to address costs/coverage and if copays may be required. Our practice is not responsible to obtain coverage for any testing that may be necessary.

Missed appointments

There will be a \$100 charge for missed office appointments without 48 hours advance notice. Additionally there is a \$250 charge for missed procedures or those without at least 48 hours advance notice.

Discharge from practice

While it is always our goal to develop an excellent physician/patient relationship, such a relationship is not always obtainable. Potential reasons why a patient may be discharged from the practice include, but are not limited to chronic missed or canceled appointments, failure to pay outstanding balances/copays, use of vulgar language/threatening behavior towards staff or physician, those seeking 2nd or 3rd opinions regarding care, and non-compliance with medical treatment. For any and all of these reasons, a patient may be asked to leave the practice with 30 days notice to find an alternate gastroenterologist.

Collection Costs

Should you fail to pay any amount due under this agreement, you agree to be responsible for any collection costs, including court costs and reasonable attorney fees, incurred by this office in collecting the amount due. By signing below, you agree that our office may contact you via phone or text message and leave messages regarding your balance.s

Questions?

We make every effort to continue to be able to take care of your healthcare needs. Should you have questions regarding your bill or have trouble making payments, please call our biller at 716-240-2296 and choose option 3 to discuss your concerns.

I certify the insurance information I have provided is accurate and correct. I authorize Saman B. Chubineh, M.D., to directly bill my insurance company on my behalf for services rendered. I have read, understand, and agree to the provisions of this Patient Financial Responsibility Form:

X _____

Patient Signature, Authorized Representative or Responsible Party
Date

X _____

Print Name of Patient, Authorized Representative or Responsible Party
Relationship to Patient

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

January 1st, 2025

This Notice of Privacy Practices applies to the following organizations.

*This Notice of Privacy Practices applies to the following organizations.
I have read, understand, and agree to the provisions of this Patient Financial Responsibility Form:*

Patient Signature, Authorized Representative or Responsible Party

Some patients choose to have their Protected Health Information (PHI) remain private. In the event that you would like your healthcare discussed with a person of your choosing, please list their name below, their relationship to you, and sign your name giving us the right to discuss your health with the person of your choosing.

Person which we may share your health information

Relationship to you

Patient Signature, Authorized Representative or Responsible Party

Privacy contact Laura Chubineh 716-240-2296, email - givny@outlook.com