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 *(Last, First)*: ¨ Male ¨ Female ¨ Non-Binary	**DOB:**

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? ¨ Yes ¨ No If so, when?		
	Does anyone in your family have a history of colon cancer or colon polyps? ¨ Yes ¨ No If so, who and at what age?		
Alcohol	Do you drink alcohol?	¨ Yes	¨ No
	If yes, what kind?		
	How many drinks per week?		
	Are you concerned about the amount you drink?	¨ Yes	¨ No
	Have you considered stopping?	¨ Yes	¨ No
Tobacco	Do you use tobacco or tobacco products?	¨ Yes	¨ No
	Cigarettes/day?	# of years?	Year quit if applicable?
Drugs	Do you currently use recreational or street drugs?	¨ Yes	¨ No
	Have you ever given yourself street drugs with a needle?	¨ Yes	¨ No
Sex	Are you sexually active?	¨ Yes	¨ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS
Father		
Mother		
Sibling	¨ M ¨ F	
	¨ M ¨ F	
	¨ M ¨ F	

OTHER PROBLEMS

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

¨ Skin	¨ Chest/Heart	¨ Recent changes in:
¨ Head/Neck	¨ Back	¨ Weight
¨ Ears	¨ Intestinal	¨ Energy level
¨ Nose	¨ Bladder	¨ Ability to sleep
¨ Throat	¨ Bowel	¨ Other pain/discomfort:
¨ Lungs	¨ Circulation	

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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.

Appeal requests

In the event that your insurance company does not cover a billed service, an appeal may be required to be sent on your behalf. By signing your name below, you give us permission to file this appeal on your behalf. Should any remaining balance remain, you may ultimately be responsible for the remaining balance.

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 of $100 for a follow up visit or $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 45-75, 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 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 within 48 hours. 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 balances.

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 - giwny@outlook.com