Patient Registration Form **Neil L. Julie, MD/ Seong Ko, CRNP**

Please complete all blocks and print information. Social security number is permitted under HIPAA.

Patient Information

Last Name:	First Name:		M.I.:
Mailing Address: If Applicable:			Apt #
City:	State:		Zip:
Home Phone:	Cell Phone:	Work Phone:	
Date of Birth:	Email:		
Where can we leave reminder calls and messages? ☐ Home ☐ Cell	Social Security:	Sex: **Male / Female**	Marital Status:
Primary Care Physician:	Pharmacy Name/Location:		
Emergency Contact:	Relationship to Patient:	Phone Number:	
Race:	Ethnicity:		
Employer Name/Location:			

Primary Medical Insurance	Secondary Medical Insurance
Insurance Company Name:	Insurance Company Name:
Policy I.D. Number:	Policy I.D. Number:
Policy Group Number:	Policy Group Number:
Policy Holder Name (If Different):	Policy Holder Name (If Different):
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy Holder's Social Security:	Policy Holders Social Security:
Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:

Be sure that you provide a referral if your insurance requires it. This will be the <u>responsibility of the patient</u>.

Statement of patient understanding

By signing this form below, I request the direct payment of authorized medical benefits (including Medicare or other major medical benefits) to be made to NEIL JULIE MD PA for any services furnished me by these providers. I authorize any holder of medical information about me to release this information to my insurance carrier (or intermediaries), to the Health Care Financing Administration and its agents, to my attorney, or to another physician's office. Also, I permit a copy of this authorization to be used in place of the original copy. This assignment will remain in effect until I revoke, in writing, this authorization. I understand that because these services were performed for me or for my legal dependent, I am financially responsible for all charges whether or not paid by the insurance carrier. I understand that if my account has to be forwarded to a collection agency, I am responsible for all collection fees, including court costs. I will review a copy of each; Facility Referral Policy, Acknowledgement of HIPAA and Financial Policy.

Patient Signature:	**Date:**

Gastroenterology: Health and Family History

Neil L. Julie, MD
Seong Ko, CRNP

Name:	Age:	Date of Visit:
Height:	Weight:	Occupation:

Smoker? YES NO If **YES,** how many packs per day? _____	**Alcohol:** ☐ Never ☐ 1-3/Month ☐ 1-3/Week ☐ Daily	**Caffeine:** ☐ Never ☐ 1-3/Month ☐ 1-3/Week ☐ Daily

Drug Allergies and Reaction:

Family Medical History:

Current Health Problems and Treating Doctor:

All Surgeries and Year:

All Current Medications (including over the counter):

Past Upper Endoscopies (Year and Results):

Past Colonoscopies (Year and Results):

Patient Statement: To the best of my knowledge, the above information is accurate and complete.

Signature: _____ Date:_____

NEIL L. JULIE, M.D.

Specializing in Gastroenterology and Hepatobiliary Diseases

To our patient:

During the course of your evaluation and treatment in our practice, you may need to be referred to an outside health care facility. For your information, Dr. Neil Julie has an ownership interest in the following health care facility:

Gastrointestinal Endoscopy Associates, L.L.C. (GIEA)

Ambulatory Endoscopy Center

If an outside referral is necessary, you are free to utilize any health care facility of your choice, subject to any restrictions which may exist under your health insurance coverage.

By signing below, you acknowledge that you have been informed of your physician's ownership interest in the above named facility. If you have any questions or concerns regarding this information, please bring them directly to the attention of your physician.

Patient or Guardian Signature

Date

NEIL L. JULIE, M.D.

Specializing in Gastroenterology and Hepatobiliary Diseases

15225 Shady Grove Road

Suite 103

Rockville, MD 20850

Acknowledgement of Receipt of; Notice of Privacy Practices

Effective Date May 1, 2008

_____ _____

Patient Name **Date of Birth**

By my signature below, I acknowledge that I have read Neil L. Julie, MD, PA Notice of Privacy Practices.

_____ _____

Patient or Guardian's Signature **Date**

If the signature above is by any individual other than the patient, please explain your authority to act for the patient:

_____

_____

FINANCIAL POLICY (Revised 01/01/2011)

Thank you for choosing Neil L. Julie, MD., PA for your health care needs. Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. Please read the following billing policies to understand your financial obligations as a patient.

INSURANCE AND PAYMENT POLICY

We participate with Medicare, the "Blues" and most major insurance plans. You should know if the physician and the facility where the procedure will be performed participate with your insurance plan. For managed care plans requiring a copay, you are responsible for paying the copay at the time of service. If your insurance is HMO or EPO and requires a referral from your primary care physician, it is your responsibility to obtain the referral prior to the appointment. Some patients have out of pocket expenses, which are not covered by your insurance, including deductibles, copayments, coinsurance, and non-covered services. When you receive your Explanation of Benefits from your insurance carrier, you are responsible for the payment in full of any balance on your account once you receive a statement from our office.

PAYMENT METHODS

We accept payment by cash, check or money order, Visa, MasterCard or Discover. For any returned check, there will be an additional service charge and we will only accept cash or money order to replace the returned check. Failure to replace the returned check may result in collection action.

SELF-PAY PATIENTS

Patients will be required to pay in full the estimated charges prior to procedures being performed. Office visits are to be paid at the time of service.

STATEMENTS SHOWING OUTSTANDING BALANCES

Statements are mailed to our patients monthly. The statement shows an itemized statement on any outstanding balance on your account. The balance should be paid in full upon receipt unless financial arrangements have been made with the billing office. Past due accounts will be reviewed for possible collection action.

APPOINTMENTS-CANCELLATIONS/RESCHEDULED

We make every effort to accommodate your scheduling needs. It is important that you arrive on time and notify us immediately in the event you need to reschedule. We reserve the amount of time we need to provide quality care. Cancelled/rescheduled PROCEDURE without sufficient notice 24 hours (2 days) will incur a charge of $125.This charge is not covered by your insurance company; therefore the charge will be billed directly to you. We will require payment of the cancellation fee prior to rescheduling. Therefore, sufficient notice to change your procedure appointment is necessary in order to offer this time to another patient. We require 48 hours notice prior to your scheduled procedure for any cancellation or rescheduling.

Office visits cancelled/rescheduled without sufficient notice (24 hours) will incur a charge of $35. This charge is not a covered charge and is not paid by your insurance company. We will require payment of this fee prior to scheduling another appointment.

DEDUCTIBLES & PRECERTIFICATION

Our office will verify your benefits with your insurance plan. Payment of any deductible amount is your responsibility. We will contact your insurance plan to obtain precertification on procedures scheduled by our office. Precertification does not guarantee coverage and/or payment. It is your responsibility to know the extent of coverage for services provided by our office.

PROCEDURE BILLINGS

For procedures performed at one of the endoscopy centers (GIEA), you will receive three bills. One is for Dr. Julie's professional service in the amount of your copay or coinsurance due, the second bill will be the facility fee billed directly from the facility, and the third for the anesthesiologist. The GIEA facility bills for anesthesia services provided during your procedure. Any pathology performed during your procedure will be billed by the entity providing the lab services.

SCREENING vs. DIAGNOSTIC COVERAGE

Insurance companies often provide screening benefits for routine screening colonoscopy. In general, a screening colonoscopy is allowed only once within a 10 year period—if you have had a previous colonoscopy within the past 10 years, this current study will not qualify as a "screening." Furthermore, a screening colonoscopy is performed when you the patient have no symptoms and there are no polyps/lesions removed during the procedure. However, if during the procedure the physician discovers polyps/lesions or performs a biopsy, the insurance plan may consider the service as a diagnostic procedure and may not cover the procedure as a "screening colonoscopy." In this case, the insurance company may drop the financial responsibility to you, the patient, for partially or all of the procedure cost. It is important that you know if this applies to your routine screening benefits.

I, the patient, have read, understood, and accepted the above financial policy of Neil L. Julie, MD, PA.

_____ _____

Signature **Date**