SHARON R. ROSEMAN, MD
Practice Limited to Gastroenterology
701 Broad Street, Suite 411
Sewickley, PA 15143
(412)749-7160 • Fax (412)749-7388
www.heritagevalley.org/sharonrosemanmd

To All of Our Patients (New and Return)

Registration Packet:

At your first visit, or if you have not been seen for a while, you will be asked to complete a Registration Packet. Due to health care regulations, we are requesting that you complete all forms in their entirety. To facilitate the registration process, please go to www.heritagevalley.org/sharonrosemanmd to complete our Registration Packet and bring it with you. If you are unable to complete your paperwork prior to your appointment, please arrive 20 minutes early. Complete the highlighted areas only of the Release of Records Form that is enclosed in this packet. This form is used to obtain medical records from other physicians to assist us with your care.

If you are scheduled for a procedure:

- It is important that you return all completed forms to our office prior to your appointment date. We need these forms in order to pre-register for your procedure.
- Include a copy of your health insurance card(s).
- Bring all of your medications with you to your procedure.

If you are scheduled for an office visit:

- Complete all forms prior to your appointment date and bring with you to your office visit.
- Bring your health insurance card(s).
- Bring all of your medications with you to your office visit.
- We do not bill for copays. Please bring your copay and/or any outstanding balance you may owe our office.

There will be a fee of $25.00 for failure to show or late notice cancellations of office visits and a $55.00 fee for all procedures and new patient office visits. To avoid being charged, please call the office one (1) business day prior to your office visit and two (2) business days prior to your procedure.

5/2018
Patient Financial Policy

Terms and Conditions

Our relationship is with you and not your insurance company. Because there are numerous insurance companies with different plans, it is your responsibility to know your benefits and the coverage of your health insurance plan. As a service for you, we will file your insurance claim as long as we have the correct insurance information. If your insurance has not paid within 60 days from submission, you are responsible for full payment.

- All co-pays and outstanding balances are required at the time of your visit. Coinsurances and deductibles may also be collected at the time of service.
- For your convenience our office accepts cash, checks and credit/debit cards.
- All past balances will be due at the time of service unless prior arrangements have been made with the Office Manager.
- Payment arrangements may be made for balances that exceed $100.00. A minimum monthly payment arrangement will be no less than $50.00. Failure to make scheduled payments may lead to discharge from the practice unless discussed with the Office Manager.
- The office will verify insurance eligibility, deductible and coinsurance amounts prior to any elective procedures that you may have. It is our policy to collect your deductible and/or coinsurance prior to your procedure. The fee that you are quoted is an ESTIMATE based on 1) anticipated procedure to be performed and 2) current information provided to the office by your insurance carrier. We will reimburse any overpayment made by you on your account.
- All checks returned for non-sufficient funds will have a $30.00 fee applied to your account.
- There is a $15.00 fee charged directly to patients if additional paperwork, such as disability or secondary insurance forms requiring completion.
- There may be an administrative charge for copying medical records. This fee is for staff time as well as supplies and equipment needed. For more detailed information, please speak to our office staff.
- There will be a fee of $25.00 for established patients for failure to show or late notice cancellations of office visits and a $55.00 fee for all procedures and new patient office visits. To avoid being charged, please call the office one (1) business day prior to your office visit and two (2) business days prior to your procedure.
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS CAREFULLY.

Heritage Valley Health System (HVHS) CONTINUES TO BE COMMITTED TO PROTECTING THE PRIVACY OF YOUR MEDICAL AND BUSINESS INFORMATION. It has been our practice not to disclose your medical information for any purpose without your written authorization. We are now required by law to provide you with this statement to inform you in writing how your medical information will be used and disclosed.

Protected Health Information, or PHI, is defined by the federal government as, individually identifiable health information that is or has been electronically maintained, electronically transmitted by a covered entity, or information when it takes any other form. PHI is a part of health information, including demographic information, collected from the individual and is created or received by a healthcare provider, relates to past, present, or future health or condition of the individual or payment for the provision of care. PHI identifies the individual directly or affords that the individual can reasonably be identified. Covered entity is defined as a healthcare provider who transmits any health information in electronic form.

We are required by law to maintain the privacy of your protected health information and to provide you with this Notice of our legal duties and privacy practices. HVHS is required by law to follow the terms of this Notice. HVHS reserves the right to change the terms of the Notice and to make any revision necessary to the protected health information we maintain. Once given, you may revoke your authorization in writing at any time. Other uses and disclosures not described in the Notice will not be made without your authorization.

Following any revisions made to this Notice, HVHS will make these changes available through distribution of the revised Notice by posting the revised Notice in HVHS facilities and on the HVHS website.

How your Medical Information May Be Used and Disclosed:

- HVHS will use your medical information as part of providing patient care. For example, your medical information will be used by the healthcare professionals providing your care, by the business office to bill for the services provided, and by selected care and quality employees who review medical information to assure quality and medical necessity of services provided.
- HVHS may contact you to provide appointment reminders or information about treatments, alternatives, or other health-related benefits and services that may be of interest to you.
- During inpatient treatment at a HVHS facility, the hospitals and consulting physicians are considered an Organized Health Care Arrangement (OHCA). This means related health information can be shared for purposes of treatment, payment, or healthcare operations.
- Unless you object, while an inpatient or outpatient of HVHS, and with the exception of behavioral health patients, HVHS:
  - will include general information, including your name, location in the hospital, your condition described in general terms, and your religious affiliation in a list or directory of individuals located in the facility where you are hospitalized. This information, except for the religious affiliation, will be released to people who ask for you by name. Your religious affiliation may be given to members of the clergy, even if they do not ask for you by name.
  - disclose to family members, other relatives or close personal friends who are responsible for your care the medical information directly relevant to that person’s involvement with your care.
  - use or disclose your medical information to notify a family member or personal representative of your location, general condition, or death.
- HVHS may also:
  - disclose your medical information to a public or private entity for the purpose of coordinating with that entity to assist in disaster relief efforts.
  - use or disclose your medical information for public health activities, including the reporting of disease, injury, vital events, and the conduct of public health surveillance, investigation, and intervention.
  - disclose medical information when requested by a licensed state or federal agency for accreditation purposes.
- disclose your medical information to a health oversight agency for oversight activities authorized by law, including audits, investigations, inspections, licensure or disciplinary actions, administrative and/or legal proceedings.
- disclose your medical information in the course of certain judicial or administrative proceedings.
- disclose your medical information for law enforcement purposes or other specialized government functions.
- disclose your medical information to a coroner, medical examiner, or a funeral director.
- if you are an organ donor, disclose your medical information to an organ donation and procurement organization.
- use or disclose your medical information for certain research purposes.
- use or disclose your medical information to prevent or lessen a serious threat to the health or safety of another person or the public.
- disclose your medical information as authorized by laws relating to worker’s compensation or similar programs.
- may contact you to raise funds for the hospital.

Your Rights Regarding Your Medical Information:

Your rights related to your medical information are as follows:
- You have the right to request restrictions on certain uses and disclosure of your medical information. HVHS is not required by law to agree to your requested restrictions except when disclosure is to a health plan for services paid exclusively by the patient.
- You have the right to receive communications from HVHS in a confidential manner.
- Your have the right to inspect and obtain a copy of your medical information. This right is subject to certain specific exceptions. You will be charged a fee for any copies of your medical information.
- You have the right to request an amendment to your medical information. HVHS may deny your request for certain specific reasons. If HVHS denies your request a written explanation for the denial and information on further rights will be provided to you.
- You have the right to receive an accounting of the disclosures of your medical information made by HVHS for six years prior to your request, effective after April 14, 2003. By law, disclosures for treatment, payment, health care operations, and certain other specific disclosures are not included in the accounting.
- If you do not wish to be contacted for fundraising efforts, you may notify us in one of three ways. In writing: Heritage Valley Health Systems Foundations, 420 Rouser Road, Suite 102, Moon Township, PA., 15108
  By calling: 412-749-7121
  Or e-mailing: foundation@hvhs.org
- You have the right to receive a paper copy of HVHS’ Notice of Privacy Practices for Protected Health Information. You have a right to submit a complaint to HVHS and/or to the United States Department of Health and Human Services if you believe HVHS has violated your privacy rights. To complain to HVHS or to request additional information on your privacy rights, please contact HVHS’ Privacy Officer by calling (724) 773-3473 or by writing to HVHS Privacy Officer, Heritage Valley Health System, 1000 Dutch Ridge Road, Beaver, PA, 15009. If you choose to file a complaint you will not be retaliated against in any way.
- Per the federal Modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification final rule published January 25, 2013, unless a specific exception as identified in 45 CFR 160 or 164 exists, you have a right to be notified of any unauthorized access, use or disclosure of your medical or business information which compromises the security or privacy of such information.

Your Medical Information and Health Information Exchanges (HIE):

HVHS participates in Health Information Exchanges (HIE). Generally, a HIE is an organization that regional hospitals, physicians, and other healthcare providers participate in to exchange patient information in order to facilitate health care, avoid duplication of services (such as tests) and to reduce the likelihood that medical error will occur. By participating in the HIE, HVHS may share your health information with other providers or participants of other health information exchanges, by example P3N (Pennsylvania Patient & Provider Network) and Healtheway (a national network that allows providers to exchange information). This health information could include, but is not limited to:
- Test Results. By example, the following tests and results:
  laboratory including microbiology; pathology; radiology/diagnostic imaging; GI; cardiac;
  neurological.
- Health Maintenance documentation
• Problem list documentation
• Allergy list documentation
• Immunization profiles
• Medication lists
• Progress notes
• Consultation notes
• Discharge instructions
• Inpatient operative reports
• Emergency Room visit discharge summary note
• Urgent Care visit progress notes
• Clinical Claims Information

Ancillary healthcare related services providers may include, but are not limited to:
• Organ Procurement
• Diagnostic Testing
• Pharmacies
• Durable Medical Equipment Suppliers
• Home Health Services

All Participating Providers have agreed to a set of standards relating to its access, sharing, use and disclosure of health information available through the HIE. These standards are intended to comply with all applicable state and federal laws. As a result, you understand and agree that unless you notify your healthcare Provider that you do not wish for your health information to be available through the HIE (“Opt-Out”):

• Health information that results from any Participating Provider providing services to you will be made available through the HIE. For clarity, if you Opt-Out, your health information will no longer be accessible through the HIE. However, your opt-out does not affect health information that was disclosed through the HIE prior to the time that you opted out.

• Regardless of whether you choose to opt-out of the HIE, your health information will still be provided to the HIE. However, if you choose to Opt-Out, the HIE will not exchange your health information with other providers. Additionally, you cannot choose to have only certain providers access your health information.

• All Participating Providers who provide services to you will have the ability to access to your information. However, Participating Providers that do not provide services to you will not have access to your information;

• Information available through the HIE may be provided to others as necessary for referral, consultation, treatment and/or the provision of other treatment-related healthcare services to you. This includes providers, pharmacies, laboratories, etc.

• Your information may be disclosed for payment related activities associated with your treatment by a Participating Provider; and your information may be used for healthcare operations related activities by Participating Providers.

• You may Opt-Out at any time by requesting an Opt-Out form from the registration staff at your point of service or in one of two ways.
  In writing: Heritage Valley Health System, Medical Records – Release of Information, 1000 Dutch Ridge Road, Beaver, PA 15009
  By emailing: roi@hvhs.org
  Please allow (2) business days for the processing of your Opt-Out request.

A list of HIE Participating Providers may be found at: www.heritagevalley.org/hie

This Notice is effective as of April 1, 2003.

Health History

Name

What is the main reason for today’s visit?

Health Habits
Please answer each question by checking the appropriate box.

Do you...

☐ Yes  ☐ No  Currently smoke cigarettes?

☐ Former Smoker  ☐ Never a smoker

☐ Yes  ☐ No  Chew tobacco?

☐ Yes  ☐ No  Drink beer?

☐ Yes  ☐ No  Drink wine?

☐ Yes  ☐ No  Drink hard liquor?

☐ Yes  ☐ No  Use aspirin, ibuprofen, ‘arthritis medications’

☐ Yes  ☐ No  Drink beverages with caffeine

☐ Yes  ☐ No  On a special diet

☐ Yes  ☐ No  Do you exercise LESS than twice a week?

Operations
What was done?  ☐ NONE

About when?

Current Medications and Dose  ☐ NONE
(Include all non-prescription medications)

Drug  Strength  How Often

Allergies to Medications  ☐ NONE

Family Health History
Do these problems run in your family? Please mark an “X” where appropriate.

<table>
<thead>
<tr>
<th></th>
<th>Father</th>
<th>Mother</th>
<th>Father’s Father</th>
<th>Father’s Mother</th>
<th>Mother’s Father</th>
<th>Mother’s Mother</th>
<th>Brothers</th>
<th>Sisters</th>
<th>Other</th>
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<td>Colon Cancer</td>
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<td>Colon Polyps</td>
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<td>Ulcerative Colitis/ Crohn’s</td>
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Sharon R. Roseman, MD, FACP
Practice Limited to Gastroenterology
Review of Systems

Please check the boxes (yes or no) for each condition mentioned below...

**General**
- □ Y □ N Unexpected weight loss
- □ Y □ N Recent weight gain
- □ Y □ N Fever or shaking chills
- □ Y □ N Night sweats
- □ Y □ N Swollen glands
- □ Y □ N Take Coumadin, Blood-thinners

**Heart and Lungs**
- □ Y □ N High blood pressure
- □ Y □ N High cholesterol
- □ Y □ N Heart disease
- □ Y □ N Heart attack in past
- □ Y □ N Fainting spells
- □ Y □ N Irregular heartbeat
- □ Y □ N Wear pacemaker
- □ Y □ N Have a defibrillator
- □ Y □ N Chest pain
- □ Y □ N Sleep apnea
- □ Y □ N Shortness of breath
- □ Y □ N Use oxygen
- □ Y □ N Can't breathe when lying flat
- □ Y □ N Awaken short of breath
- □ Y □ N Ankle swelling
- □ Y □ N Heart murmur
- □ Y □ N Mitral valve prolapse
- □ Y □ N Artificial valve
- □ Y □ N Frequent cough
- □ Y □ N Cough up sputum
- □ Y □ N Cough up blood
- □ Y □ N Wheezing or asthma
- □ Y □ N Rheumatic fever as child

**Kidneys**
- □ Y □ N Kidney stones
- □ Y □ N Kidney disease
- □ Y □ N Frequent urination
- □ Y □ N Up nights to urinate
- □ Y □ N Blood in urine
- □ Y □ N Painful urination
- □ Y □ N Slow urination
- □ Y □ N Leakage of urine

**Brain**
- □ Y □ N Epilepsy or seizures
- □ Y □ N Past strokes

**Emotions**
- □ Y □ N Often depressed
- □ Y □ N Cry easily
- □ Y □ N Overly anxious
- □ Y □ N Can't handle stress

**Men only**
- □ Y □ N Lump in testicles
- □ Y □ N Penis discharge
- □ Y □ N Erection difficulties

**Women only**
- □ Y □ N Pregnant now
- □ Y □ N Planning pregnancy
- □ Y □ N Nipple discharge
- □ Y □ N Lump in breast
- □ Y □ N Vaginal discharge
- □ Y □ N Hot flashes
- □ Y □ N Non-period bleeding
- □ Y □ N Past menopause
- □ Y □ N Painful intercourse
- □ Y □ N Change in periods
- □ Y □ N Past endometriosis

**Other Condition(s):**

Thank you for completing this questionnaire.
PATIENT INFORMATION

NAME: LAST FIRST MIDDLE INITIAL SEX BIRTHDATE

ADDRESS: STREET CITY STATE ZIP SOCIAL SECURITY #: MARITAL STATUS

HOME PHONE # CELL PHONE # DAYTIME PHONE # OCCUPATION

( ) ( ) ( ) CIRCLE ONE

FT PT RET Not Employed

PHARMACY NAME: PHARMACY PHONE # ARE YOU A STUDENT?

( ) Yes No Part time Full time

RACE (MARK ONE) ETHNICITY (MARK ONE)

American/AK Indian Black/African American
Asian/Pacific Islander Hispanic
White Unknown/Decline

Will the patient be best served in a language other than spoken English? □ No □ Yes If yes, please specify:

PRIMARY CARE PHYSICIAN

PRIMARY CARE PHYSICIAN’S NAME:

ADDRESS: STREET CITY STATE ZIP

TELEPHONE #: FAX#

( ) ( )

INSURANCE INFORMATION

***PLEASE HAVE CARDS READY FOR STAFF TO COPY***

NAME OF PRIMARY INSURANCE CO.

INSURED’S NAME (Subscriber of insurance) SUBSCRIBER’S BIRTHDATE

ID # OR AGREEMENT # GROUP #

EFFECTIVE DATE AMOUNT OF CO-PAY FOR OFFICE VISITS and SPECIALIST'S VISITS:

NAME OF SECONDARY INSURANCE CO

INSURED’S NAME (Subscriber of insurance) SUBSCRIBER’S BIRTHDATE

ID # OR AGREEMENT # GROUP #

EFFECTIVE DATE:

DO YOU HAVE OTHER INSURANCE THAT WILL PAY THIS ACCOUNT?

You are required to complete an additional form. □ Automobile □ Workmen’s Comp □ Other

EMERGENCY CONTACT

Please name a person who does not live with you to contact in case of an emergency or in the event that we are unable to reach you.

NAME / RELATIONSHIP:

TELEPHONE # - HOME ( )

TELEPHONE # - WORK ( )

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and other health plans to Heritage Valley Medical Group/ as noted above. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

SIGNED: ___________________________ DATE: 06/2012

PATIENT OR RESPONSIBLE PARTY

Please read and sign back page
ASSIGNMENT OF BENEFITS

☐ MEDICARE PATIENTS:
I request that payment of authorized Medicare benefits be made either to me or on my behalf to the name of the provider of service and/or supplier for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related service.

We do accept Medicare assignment, however, you are responsible for your Medicare deductible. Many co-insurance plans do not cover the Medicare deductible and you will be billed. It is your responsibility to know if your co-insurance does not cover this. In addition, if the 20% after Medicare is not paid by your co-insurance, it is your responsibility to contact them regarding this. Please note: we will file your co-insurance one time only.

I have read the above and fully understand my financial obligation.

Date ____________________________ Patient Signature ____________________________ HIC # ____________________________

☐ MEDIGAP PATIENTS:
I request that payment of authorized Medigap benefits be made either to me or on my behalf to the name of the provider of service and/or supplier for any services furnished to me by that provider of service and/or supplier. I authorize any holder of Medicare information about me to release to ____________________________ (Name of Medigap insurer) and its agents any information needed to determine these benefits payable for related service.

I have read the above and fully understand my financial obligation.

Date ____________________________ Patient Signature ____________________________ HIC # ____________________________

☐ BLUE SHIELD PATIENTS
We participate in a variety of Pennsylvania Blue Shield plans in addition to Blue Shield plans of other states. You will be billed for any applicable co-payments and deductibles. I understand that payment for office visits is due in full at the time of the visit.

☐ COMMERCIAL HEALTH INSURANCE PATIENTS
As a courtesy to our patients, when we have your complete insurance information, a claim is automatically submitted to your insurance carrier unless we are instructed otherwise. In some cases, you will receive payment. You are personally responsible for payment of the entire account. We will assist you; however, any questions related to delayed payment or denial should be directed to your insurance company and not to our office.

☐ HMO AND PPO PATIENTS
We participate in numerous HMO and PPO programs. Due to the varied guidelines defined by each plan, it is your responsibility to know your specific plan. Additionally, in certain programs, you will be responsible for any co-payments that apply.

☐ SELF PAY PATIENTS
Payment for services rendered is due at the time of service unless other arrangements have been made prior to your appointment. Your prompt payment is appreciated. We do not want your health care to be a financial hardship to you. If you have any difficulties, our billing department will help to establish a payment program to accommodate your needs.

I have read the item checked above and fully understand my financial obligation.

Date ____________________________ Patient Signature ____________________________ 06/2012
Advanced Beneficiary Notice “ABN” and Benefit Information

If you are having a screening colonoscopy, you will be asked to sign an Advanced Beneficiary Notice or “ABN”. You do not need an ABN if your colonoscopy is scheduled to evaluate problems or symptoms of concern to you and your doctor.

What is an Advanced Beneficiary Notice or “ABN”?
An ABN is a form that lets you know that you may be responsible to pay for your colonoscopy if your insurance refuses. The ABN helps you to make an informed decision about whether to obtain the service and pay for it or choose not to receive it.

Why would my insurance refuse to pay?
Insurances may not pay for a routine screening colonoscopy due to frequency limitations. Frequency limitations are for services that have a specific time frame between services. For example, Medicare allows one screening colonoscopy every 10 years for “average risk” patients. If the patient wants a screening colonoscopy more often, Medicare will pay for the first exam and the patient will pay for additional screenings up to ten years. If the patient fits Medicare’s guidelines for “high risk” they are allowed to have the colonoscopy every two years.

Why do you want me to sign the ABN?
If you had a screening colonoscopy performed by another physician, we may not be aware of the time period. We ask patients to sign an ABN whenever the insurance may deny payment for frequency limitations.

How do I know if I’m “average risk” or “high risk”?
Patients at average risk, means:
- No personal history of polyps, colorectal cancer, inflammatory bowel disease, including Crohn’s disease and ulcerative colitis
- No family history of colorectal cancers or polyps.

Patients at high risk, means:
- Having a close relative (sibling, parent, or child) who has had colorectal cancer or colon polyps. A close relative is a sibling, parent or child.
- A personal history of colon polyps.
- A personal history of inflammatory bowel disease, including Crohn’s disease and ulcerative colitis.

Call your insurance company to make sure a screening colonoscopy is a covered service under your health plan. The codes most insurance companies use are G0105 (high risk patients), G0121 (average risk patients) and a few insurance companies use the code 45378 with the reason (diagnosis) code Z12.11.

If you have an HMO plan, you will also want to check with your insurance to see if you need a referral or authorization. If you do, let us know immediately so we can take care of that for you.
Advanced Beneficiary Notice

HVMG Gastroenterology

Patient Name: ____________________________ Date of Birth: __________________

Your insurance will only pay for services that it determines to be “reasonable and necessary”. If your insurance determines that a particular service, although it would otherwise be covered, is “not reasonable and necessary” under your insurance program standards, your insurance will deny payment for that service.

BENEFICIARY AGREEMENT

I have been notified by my physician that he/she believes that, in my case, my insurance is likely to deny payment for the service(s) identified below, for the reason(s) stated. If my insurance denies payment, I agree to be personally and fully responsible for payment.

<table>
<thead>
<tr>
<th>Date of Service</th>
<th>Procedure/Service</th>
<th>Reason #</th>
<th>Patient’s Signature</th>
<th>Date Signed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Screening Colonoscopy</td>
<td>7</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

My insurance may deny payment for the following reason(s):

1. My insurance usually does not pay for this many visits, treatments or manipulations.
2. My insurance usually does not pay for this shot.
3. My insurance usually does not pay for this many shots.
4. My insurance usually does not pay for this because it is a treatment that has yet to be proven effective.
5. My insurance does not pay for this office visit unless it is needed because of an emergency.
6. My insurance usually does not pay for like services by more than one doctor during the same time period.
7. My insurance usually does not pay for this many services within this period of time.
8. My insurance usually does not pay for more than one visit a day.
9. My insurance usually does not pay for such an extensive procedure.
10. My insurance usually does not pay for like services by more than one doctor of the same specialty.
11. My insurance usually does not pay for this equipment.
12. My insurance usually does not pay for this lab test.
13. My insurance usually does not pay for this service for the reported condition.
14. Other (Describe): ____________________________________________________________________
Sharon R. Roseman, M.D.
Authorization to Disclose Medical Information

The information in my medical record may be released to the following individuals either by phone or in consultation by the office of Dr. Sharon R. Roseman. Absolutely no information will be release to anyone other than the patient and/or the following individuals listed below.

I hereby authorize the release of information from the record of:

<table>
<thead>
<tr>
<th>Patient Name (Please PRINT)</th>
<th>Date of Birth</th>
</tr>
</thead>
</table>

Name of Person able to obtain information on my behalf:  
1)                        
2)                        
3)                        
4)                        

Relationship to Patient:  

HIV, Behavioral Health and Drug & Alcohol information contained in the medical record will be released through this authorization unless otherwise indicated.

DO NOT release:  
☐ HIV  
☐ Behavioral Health (Psychiatric)  
☐ Drug & Alcohol

I authorize Dr. Sharon R. Roseman and her staff to leave detailed medical information on my voice mail at the following telephone number:

(________________________)  
(Telephone Number)

Patient Signature:  

Date:  

I understand that this authorization will stay in effect until revoked by me in writing.
FINANCIAL POLICY ACKNOWLEDGEMENT FORM

I understand that I am responsible for all procedural charges including co-payments, deductibles, co-insurance and charges not covered by my insurance.

All patient out-of-pocket responsibility and past due balances must be paid in full prior to your procedure date unless payment arrangements are made with the Office Manager.

For Screening Colonoscopy Procedures
If our office has been asked to schedule you for a screening colonoscopy please read the following information. Patients who have screening examinations have no signs or symptoms (i.e., change in bowel habits, diarrhea, constipation, bleeding, etc.). If an abnormality or polyp is found and removed during the colonoscopy, your insurance may no longer consider the procedure to be a screening examination. This may change your insurance benefit coverage.

Why am I asked to sign an Advanced Beneficiary Notice (ABN)?
Certain services that are covered by your insurance are only covered up to a certain number of times within a specified timeframe. This means that your insurance may not pay if you exceed that limit on the service. By signing the ABN, you acknowledge that we informed you of this information in order for you to make a decision about whether to obtain the service or not. If you have questions about your insurance coverage, please contact Member Services (telephone number on the back of your insurance card).

I acknowledge that I have received a copy of the office Patient Financial Policy.

(Print Patient Name)                                      (Date of Birth)

(Patient Signature)                                      (Date)

(Witness Signature)                                      (Date)
HERITAGE VALLEY HEALTH SYSTEM
CORPORATE COMPLIANCE PROGRAM
Receipt of Notice of Privacy Practices
Acknowledgement Statement

I acknowledge I have received a copy of Heritage Valley Health Systems Notice of Privacy Practices for Protected Health Information.

Patient Name (please print)

Patient Signature

Date

In the event of the patients emergency condition, signature of person receiving Notice for patient.

*****************************************************************************
*FOR OFFICE USE ONLY
COMMENTS
*****************************************************************************
AUTHORIZATION FOR
RELEASE OF INFORMATION
TO BE SENT TO OUR PRACTICE
(Please print clearly)

PATIENT INFORMATION:
Name: First_________________________Middle__________Last________________________
Social security number________________________Date of birth________________________

I THE UNDERSIGNED, HEREBY AUTHORIZE:
Practice or Doctor's Name:________________________Phone #________________________
Address: Street________________________City________________________State_____Zip_____

TO PROVIDE:

HVMG Gastroenterology
Sharon R. Roseman, MD
701 Broad Street, Suite 411
Sewickley, PA 15143
PH: 412-749-7160 FAX: 412-749-7388

WITH THE FOLLOWING INFORMATION:

☐ Medical Records Summary (includes doctors’ notes, hospital records, laboratory and diagnostic tests within past two years, medication list, problem list, most recent EKG, immunization record, and living will/advance directives). If records are being sent for a specialist consultation, the most pertinent records will be sent.
☐ Other_________________________________________________________For dates of service: from__________ to__________

PURPOSE OF DISCLOSURE: ☐ I am transferring to this practice ☐ Other_________________________________________________________

Expressed Authorization: **Signature Required**
I understand that my medical record may contain information related to:
• Acquired Immunodeficiency Syndrome (AIDS) or infection with HIV
• Psychiatric Care
• Treatment for alcohol and/or drug abuse.

☐ I give my consent for release of this information: ____________________________Signature__________Date__________

☐ I DO NOT give consent for release of this information: ____________________________Signature__________Date__________

This authorization for release of information is valid for 90 days from the date of signature, unless revoked by written notice to the providing institution, provided the notice is received prior to the release of information. I understand that signing this authorization is voluntary, and Heritage Valley Health System cannot deny me treatment for not agreeing to sign this authorization. I understand that I may see a copy of the information described on this form and that there may be a fee associated with copying. I understand that once the above information is disclosed, it may not be under control of Heritage Valley Health System and may not be protected by federal privacy regulations, therefore there is a potential for unauthorized re-disclosure. I understand that this authorization may be revoked at anytime. I understand that if I do revoke the authorization, I must do so in writing and present my written revocation to be filed in my medical record, which will not apply to information that has already been disclosed in response to this authorization. If I have questions about the disclosure of my health information, I may contact the Office Manager or the Privacy Officer of Heritage Valley Health System. I hereby certify that I have read this authorization and agree to its terms.

Required: Signature of Patient ____________________________Date__________

*Signature if other than patient (use P.O.A. documentation) ____________________________Relationship__________Date__________

Signature of witness ____________________________Date__________

Patient EHR Questionnaire

Dr. Patrick and Dr. Roseman implemented a new Electronic Health Record (EHR) beginning November 2014. We ask that you answer a few questions regarding electronic communications with our office.

Patient Name: ________________________________________ DOB: ___________________

E-mail Address: ________________________________________

1. Do you have access to a computer?  ☐ YES  ☐ NO

2. In the future, do you want to receive your test results electronically?  ☐ YES  ☐ NO

Receiving results electronically will allow you to check your labs and/or radiology reports to include physician comments at your convenience 24 hours a day. If your results are a concern, you will receive a telephone call from our office.

3. Are you enrolled in our patient portal “Health Link”?  ☐ YES  ☐ NO

4. What is your preferred way of communicating your results?