Macomb
Gastroenterology, P.C.

RENE R. PELEMAN, M.D.
INGE HANSCHU, P.A.-C

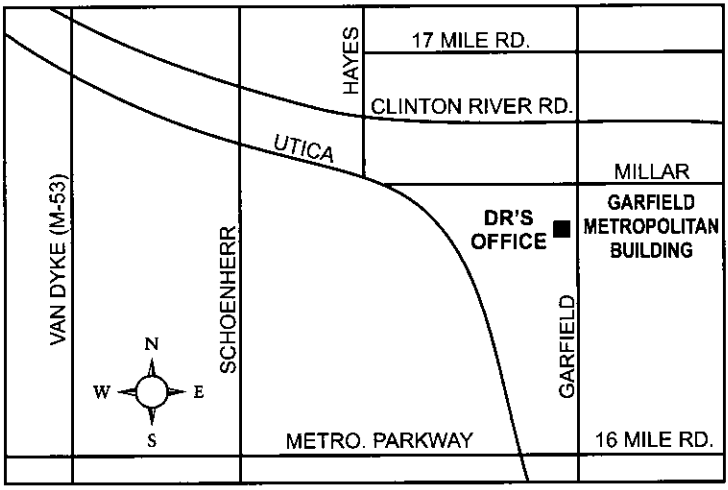
37555 Garfield, Suite 125
Garfield Metropolitan Building
Clinton Township, MI 48036
Phone (586) 263-7150
Fax (586) 263-3212

Dear Patient:

Thank you for scheduling your appointment with Macomb Gastroenterology. Your appointment is set for

_____ at _____.

Please bring the enclosed registration forms along with a photo ID such as a driver's license and your insurance cards.
HMO patients will not be seen without valid referrals.
Please avoid wearing perfumes or other fragrances to this appointment.
Appointments not cancelled within 24 hours of appointment time may be subject to NO SHOW fees.



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PATIENT INFORMATION

PLEASE PRINT CLEARLY

DATE _____

M W S D

PATIENT NAME _____ DOB _____ AGE _____ SEX _____

ADDRESS _____ PHONE NUMBER _____

CITY _____ STATE _____ ZIP _____

EMPLOYER _____ OCCUPATION _____

ADDRESS _____ PHONE NUMBER _____

_____ SS # _____

RESPONSIBLE PARTY _____ DOB _____ RELATIONSHIP _____
(If other than patient)

SPOUSE'S NAME _____ DOB _____

EMPLOYER _____ OCCUPATION _____

ADDRESS _____ PHONE NUMBER _____

_____ SS # _____

PERSON TO CONTACT IN AN EMERGENCY _____ PHONE NUMBER _____

REFERRED BY _____

ASSIGNMENT OF BENEFITS:

I hereby assign payment of authorized Medicare benefits and any other medical and/or surgical benefits, to include major medical benefits to which I am entitled, to be made either to me or on my behalf to Macomb Gastroenterology, P.C. for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release any information needed to determine these benefits payable for related services.

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 payment.

_____ _____

Date Signature

_____

Witness

INFORMATION FOR YOUR PHYSICIAN

Please answer the following questions prior to your first examination.
It will help your physician to know not only about your health but also about your family and relatives.

TODAY'S DATE

NAME | ADDRESS

TELEPHONE NUMBER | DATE OF BIRTH | AGE | PLACE OF BIRTH | LIST ANY FOREIGN TRAVELS

ETHNICITY | LANGUAGE SPOKEN | NATIONALITY | RACE

ALIVE ▸ DECEASED ▸	FATHER ☐ ☐	Present health or cause of death	MOTHER ☐ ☐	Present health or cause of death	SPOUSE ☐ ☐	Present health or cause of death
BROTHERS ▸	NO. ALIVE	HEALTH		NO. DECEASED	CAUSE OF DEATH	
SISTERS ▸	NO. ALIVE	HEALTH		NO. DECEASED	CAUSE OF DEATH	
CHILDREN ▸	NO. ALIVE	AGES & HEALTH		NO. DECEASED	AGES & CAUSE OF DEATH	

CHECK ILLNESSES WHICH HAVE OCCURRED IN ANY OF YOUR BLOOD RELATIVES ☐ Diabetes ☐ Cancer ☐ Bleeding tendency ☐ Kidney disease
☐ Tuberculosis ☐ Heart disease ☐ Stroke ☐ High blood pressure ☐ Nervous illness ☐ Allergy ☐ Other

CHECK ANY ILLNESSES OR CONDITIONS YOU HAVE HAD ☐ Diabetes ☐ Glaucoma ☐ Heart trouble ☐ Syphilis ☐ Vein trouble
☐ Cancer ☐ Asthma ☐ Juandice ☐ Gonorrhea ☐ Bleeding tendencies ☐ Tuberculosis ☐ Pneumonia ☐ Kidney disease
☐ Rheumatic fever ☐ Nervous disorder ☐ Other

LIST OTHER ILLNESSES NOT REQUIRING OPERATION FOR WHICH YOU WERE HOSPITALIZED

HAVE YOU HAD SERIOUS INJURY, BROKEN BONES, ETC.?
☐ No ☐ Yes ▸ LIST

HAVE YOU HAD ALLERGY OR SENSITIVITY TO MEDICINES OR OTHER SUBSTANCES?
☐ No ☐ Yes ▸ LIST

DO YOU USE TOBACCO NOW? ☐ No ☐ Yes	IN THE PAST? ☐ No ☐ Yes	TYPE AND DAILY AMOUNT	HOW LONG?
DO YOU USE ALCOHOLIC BEVERAGES? ☐ No ☐ Yes	TYPE	WEEKLY AMOUNT	HOW LONG?
DO YOU DRINK COFFEE? ☐ No ☐ Yes		WEEKLY AMOUNT	HOW LONG?

I WISH TO RECEIVE A COPY OF MY OFFICE VISIT NOTES
☐ No ☐ Yes

CHECK THE DISEASES AGAINST WHICH YOU HAVE BEEN IMMUNIZED
☐ Small Pox ☐ Tetanus ☐ Typhoid ☐ Polio ☐ Influenza ☐ Other

PREVIOUS OPERATIONS (Dates, hospitals and name of surgeon)

DENTAL (List any problems you have now)

MEDICATIONS (Name or otherwise identify medicines now or recently used)

ONSET DATE OF LAST MENSTRUAL PERIOD	PERIODS ARE ☐ Regular ☐ Irregular	NUMBER OF PREGNANCIES	NUMBER OF MISCARRIAGES
HAVE YOU TAKEN CORTISONE-TYPE DRUGS? ☐ No ☐ Yes	ORAL CONTRACEPTIVES ☐ No ☐ Yes	HAVE YOU RECEIVED A BLOOD TRANSFUSION? ☐ No ☐ Yes ▸ DATE:	
DRESSED WEIGHT	HOW LONG HAVE YOU BEEN AT THIS WEIGHT?		

WHAT IS YOUR MAIN MEDICAL PROBLEM AND HOW LONG HAVE YOU HAD IT?

WHAT IS YOUR MAIN SYMPTOM?

REVIEWED BY (Physician) | DATE

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FINANCIAL POLICY

PATIENT INFORMATION		
Name:	Date of Birth:	Today's Date:

Thank you for choosing us as your health care provider. We are committed to providing you the best possible medical care. Please understand that payment of your bill is important. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

Regarding Insurance:
As a courtesy our office will bill your insurance for the services you will receive. We cannot bill your insurance company unless you give us correct information. **It is your responsibility to inform us if your insurance has changed at any time during treatment**. Please understand that your bill is ultimately your responsibility whether your insurance company pays or not. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance has not paid your account in full in a timely manner, it will then become your responsibility to pay the balance. We accept Cash, Check, Visa and Mastercard. You will be charged a $25 fee for any returned check. Any account over 90 days old without payment is subject to being sent to a collection agency.

******All co-pays are due at the time of visit. If you do not pay your co-pay at the time of the visit there will be a $5.00 service fee added to your bill.******

Credit card on file for remaining balance:
With your written permission we are able to keep your credit card information (Visa or Mastercard) on file to charge for remaining balances not covered by your insurance company.

Referral and Pre-Authorizations:
If your insurance company requires a referral from your primary care physician, you **MUST** present this to our staff before being seen. If you do not obtain your referral when your insurance company requires one, you will be asked to reschedule your appointment. It is your responsibility to obtain your referral.

Missed Appointments and Cancellation Fee:
Due to the amount of time allotted for scheduled appointments, we do request at least 24 hours notice for cancellation of appointments. **It is our policy to charge $75.00 for any [redacted] patient who does not give 24 hour notice for cancellation of appointments.** The charge for a late cancellation/broken appointment will be billed directly to you and not your insurance. Please help us to serve you better by keeping your scheduled appointments.

Ancillary Services:
Please be aware that there is a $35.00 charge for services such as completing disability forms and/or forms related to your care. If you require copies of your medical records the first five pages are available to the patient free of charge and every page after is $1.00 per page.

Patient Balances/Late Fee:
If payment is not received within 30 days of the statement, a $10.00 late fee each month will be applied to your balance until payment is received.

Thank you for understanding our Financial Policy. Please let us know if you have any questions.
I authorize Macomb Gastroenterology, P.C. or my insurance company to release any information required for processing my insurance claim. I also authorize my insurance benefits to be paid directly to the physician.

I have read the Financial Policy in full and I understand and agree to this policy.

Signature of Patient/Guardian _____ Date _____

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PATIENT INFORMATION UPDATE

Patient Name _____ Date of Birth _____

Phone Contacts
Cell _____
Home _____
Work _____
Please circle main contact number CELL WORK HOME

Primary Care Physician _____
Phone # _____

Preferred Local Pharmacy
Name _____

Address _____

Phone _____

Mail Order Pharmacy (if any) _____

The Federal government now mandates us to collect and maintain records on the following information. Please complete:

Race _____ or check Declined to answer ____

Ethnicity (check one) Hispanic or Latino ____ Not Hispanic or Latino ____
Declined to answer ____

Primary Language _____

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PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name: _____

Birthdate: _____

Signature: _____

Date: _____

Please list below the names of any individuals whom you wish to have access to your medical records. Please indicate their relationship to you.

_____

_____

_____

_____

_____

This authorization will remain in effect until otherwise rescinded in writing by the patient named above.

RISK ASSESSMENT FOR HEREDITARY CANCER SYNDROMES

Patient Name: _____ Physician Name: _____

Date of Birth: _____ Today's Date: _____

Please complete this form to the best of your ability. Circle Y or N (yes or no) on the left side to indicate if you have the particular history of cancer in your family.
In the boxes provided, enter the relative and age that cancer was found (or approximate age)

Has a family member tested positive for a BRCA or Lynch Mutation? YES ☐ NO ☐

Have YOU ever been tested for hereditary cancer syndromes? YES ☐ NO ☐

* Lynch syndrome cancers include: colorectal, uterine (endometrial), ovarian, stomach, small bowel, brain, or kidney/urinary tract.

		FAMILY HISTORY OF CANCER	SELF	1st Degree: parents, children, siblings 2nd Degree: aunts/uncles, nieces/nephews and grandparents 3rd Degree: great grandparents, great aunts/uncles, cousins	
				MOTHER'S SIDE	FATHER'S SIDE
(Y)	N	*EXAMPLE: Breast cancer **BEFORE AGE 50***	-----	----------	*Aunt, age 48*
Y	N	Ovarian **OR** Pancreatic cancer 1st **OR** 2nd degree relative, **AT ANY AGE**			
Y	N	Breast cancer, 1st **OR** 2nd degree relative, **BEFORE AGE 50**			
Y	N	**YOU** had/have breast cancer **AT ANY AGE**			
Y	N	3 or more breast cancers **AT ANY AGE, Same Side of Family**			
Y	N	Ashkenazi Jewish ancestry and 1 breast cancer **AT ANY AGE, 1st or 2nd degree relative**			
Y	N	Triple Negative Breast cancer, **Before Age 60** (ER,PR and HER negative receptor status)			
Y	N	**Male Breast** cancer **AT ANY AGE**, 1st or 2nd **OR** Metastatic Prostate cancer, 1st degree only			
Y	N	1 1st degree relative with colon or uterine (endometrial) cancer, **BEFORE AGE 50**			
Y	N	1 1st or 2nd degree relative with colon or uterine (endometrial) cancer **BEFORE AGE 50** and a 2nd *Lynch cancer, **AT ANY AGE, Same Side of Family**			
Y	N	3 or more colon, uterine (endometrial) or *Lynch cancers **AT ANY AGE, Same Side of Family**			
Y	N	**YOU** have/had colon or uterine (endometrial) cancer **BEFORE AGE 65**			

Patient Signature confirming accurate updated cancer family history _____

FOR OFFICE USE ONLY

Patient meets criteria for genetic testing: ☐ YES ☐ NO

Does patient require Update Testing? ☐ YES ☐ NO
(Patient previously tested prior to 2014, i.e. non-myRisk)

Patient Accepted or Declined genetic testing: ☐ Accepted ☐ Declined

Healthcare Provider Signature: _____