David Bub, MD, PC, FACS, FASCRS

Contact Information Form

HIPAA PRIVACY INFORMATION:

In accordance with HIPAA guidelines, we will be sending all appointment reminders, statements, reports, etc. to you via mail or email unless otherwise instructed by you or your representative.

I authorize Dr. Bub and/or his staff to leave appointment and/or medical information:

Phone #/Email Address	Appointment Information	Medical Information
Home: ____	Yes or No	Yes or No
Mobile: ______________________________________	Yes or No	Yes or No
Mobile Text: __________________________________	Yes or No	Yes or No
Work: ____	Yes or No	Yes or No
With another person: Name: _______________________________________ #: ____	Yes or No	Yes or No
Via Email: ____________________________________	Yes or No	Yes or No
Via Portal:	Yes or No	Yes or No
Via Mail (USPS):	Yes or No	Yes or No

Pharmacy (name, location and/or phone #) ____

Emergency Contact Information:

Name	Phone#	Relationship

Printed name of patient:____**Date:**_______________

Signature of patient/guardian: ____

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Patient Authorization/Policy Form

Patient name: ______________________________ Date of Birth: ______________

Authorization must be given to our Practice to submit a claim to your insurance:
By my signature below, I am authorizing my insurance company, either commercial or Medicare/Medigap to release payment for services I received to the practice of David Bub, MD, PC. I authorize any holder of medical information regarding me to release to the Health Care Financing Administration (including secondary coverage) needed to determine benefits payable for related services. I hereby authorize my insurance carrier to furnish David Bub, MD, PC any information regarding my claims under Title XVIII of the Social Security Act. I am also authorizing release of information necessary to file my claim with my insurance carrier and I assign benefits payable to David Bub, MD, PC as indicated on submitted claims. I understand that I am financially responsible for any balance not covered by my insurance company. A copy of my signature is valid as the original if requested

Signature of Patient or representative: ___________________________________ Date: _____________

NOTICE OF PRIVACY PRACTICES: I am aware of the Privacy Practices of David Bub, MD, PC and any associates which describe the use and disclosure of protected health information and how I may access my protected health information and exercise my rights concerning protected health information. I may review the current practice policy prior to signing this acknowledgement/consent. (NOTE: The Practice reserves the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health records that we maintain including information created or obtained prior to the date of the effective date of change. The Notice of Privacy Practices is displayed in the office.) I authorize the office to use my health information for treatment, payment, and healthcare operation purposes consistent with the Notice of Privacy Practices

Signature of Patient or representative: ___________________________________ Date: _____________

CANCELLATION POLICY: Due to the nature of our specialty of care we reserve a specific block of time and staffing for each patient, and it is important that you make every effort to keep your appointments whether they are scheduled in our office or at an outside medical facility. Upon scheduling each patient's appointment/procedure a significant amount of paperwork, staff scheduling, equipment reservation, etc. go into preparing for that treatment. Last-minute cancellations cause disruptions within our office and/or at the medical facility where you have been scheduled and prevent other patients from receiving needed treatment. We do understand that there are valid reasons for rescheduling, such as family emergencies. However, we do want to make you aware that re-scheduling may result in a $100 fee not payable by your insurance. If you have any questions, please speak to the office staff.

Signature of Patient or representative: ___________________________________ Date: _____________

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No Surprise Billing Act

Congress has passed an act called the “No Surprise Billing Act” to protect patients from receiving surprise medical bills resulting from out-of-network care for emergency services and for certain scheduled services without prior consent. We want to make our patients aware of our commitment to providing the best possible transparency in our billing procedures. Our goal is to provide our patients with excellent medical care while controlling administrative costs. We ask that you read the statement below to understand our billing practices and acknowledge with your signature. Please retain a copy of our cancellation policy for your records (separate).

- All patients must provide accurate and complete personal & insurance information prior to being seen by our providers. All insurance cards must be presented at every visit.
- All applicable co-payments, personal balances both current and prior must be paid when the statement is sent or when contacted by the office.
- We accept cash, check (unless in collection), and credit cards.
- Our practice participates with many health insurance companies. It is your responsibility to check with your insurance regarding Doctor participation and covered services. You are responsible for all needed referrals to our practice if your insurance mandates this.
- A billing statement will be sent to you within 30 days of a response from your insurance. If you are unable to pay in full, please contact us Monday, Tuesday or Thursday of the week. We do offer payment plans.
- Providing we are participating with your insurance, we will accept their payment with the exception of co-insurances, deductibles and co-pays which you are responsible for. All co-pays must be paid at the time of your visit.
- If we are not participating with your insurance, you will be asked to make a payment for any office visit or procedure. We will bill your insurance and if payment is received, you will be reimbursed the difference.
- We offer self-pay prices for those that do not have insurance and we will discuss that with you if a procedure needs to be done, however, please understand that this is only pertaining to our provider fees and not ancillary facilities.
- If a check is returned from the bank, a fee will be added to your account to cover costs.
- Accounts that are past due or not addressed by you after trying to contact you will be referred to our collection agency.
- For any inquiries or concerns, please contact our office at (610) 433-7571.

It is our intention to make billing easier for you and not give you any “surprises.” We will make every attempt to satisfy your questions and help you with your inquiries.

Signature of Patient
(or representative) ____ Date __________________

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Medical History Form

Date: _________________

PATIENT NAME: ____ Date of Birth: _________________________

How did you hear about us?: _________________________ Primary Care Provider: ___________________________

Other Treating Physicians: ____

ALLERGIES: Please list all medications, latex, dyes, foods, etc.

Allergy List	Reaction
________________________________	_______________________________
________________________________	_______________________________
________________________________	_______________________________
________________________________	_______________________________
________________________________	_______________________________

MEDICATIONS: Please list all medications & drugs including over the counter, herbal supplements, vitamins.

Name	Dosage/Amount	Frequency

DO YOU HAVE OR HAVE YOU HAD:

__Y __N Acid Reflux
__Y __N Anxiety Disorder
__Y __N Asthma
__Y __N Atrial Fibrillation
__Y __N Bleeding Disorder
__Y __N Cancer – What type? __________________
__Y __N Coronary Artery Disease
__Y __N Coronary Stents
__Y __N Deep Vein Thrombosis (blood clot leg)
__Y __N Defibrillator
__Y __N Depression
__Y __N Diabetes, Insulin
__Y __N Diabetes, Non-Insulin
__Y __N Diverticulitis
__Y __N Drug Addiction
__Y __N Emphysema

__Y __N Fibromyalgia
__Y __N Glaucoma
__Y __N Gout
__Y __N Heart Attack
__Y __N Heart Murmur
__Y __N Hepatitis
__Y __N Hiatal Hernia
__Y __N High Blood Pressure
__Y __N High Cholesterol
__Y __N HIV or AIDS
__Y __N Hypothyroidism
__Y __N Kidney Disease
__Y __N Kidney Stones
__Y __N Leukemia/Lymphoma
__Y __N Liver Disease
__Y __N Migraine Headaches
__Y __N MRSA
__Y __N Organ Transplant

__Y __N Osteoarthritis
__Y __N Osteoporosis
__Y __N Pacemaker
__Y __N Peptic Ulcer Disease
__Y __N Peripheral Vascular Disease
__Y __N Pneumonia
__Y __N Poliomyelitis
__Y __N Psoriasis
__Y __N Psychiatric Disorder
__Y __N Pulmonary Embolism (blood clot lung)
__Y __N Rheumatoid Disease
__Y __N Seizure Disorder
__Y __N Sleep Apnea
__Y __N Stroke or Mini Stroke (TIA)
__Y __N Tuberculosis
__Y __N COPD
__Y __N Skin Disease _____________

Please list any other conditions not mentioned above: ____

Do you or anyone in your family have malignant hyperthermia? ___Y ___N

OVER →

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REVIEW OF SYSTEMS: Do you have or have you had any of the following?

HEAD/EARS/EYES
__Y __N Cataracts
__Y __N Recent change in vision
__Y __N Head injury
__Y __N Ringing in the ears
__Y __N Hearing loss
__Y __N Hearing aid
__Y __N Other:____________

NOSE/SINUSES
__Y __N Hay fever/seasonal allergies
__Y __N Frequent nose bleeds
__Y __N Other:____________

SKIN
__Y __N Skin cancer
__Y __N Itching
__Y __N Wound healing problems
__Y __N Other:____________

MOUTH/THROAT
__Y __N Bleeding mouth/gums
__Y __N Difficulty swallowing
__Y __N Dentures
__Y __N Other:____________

CARDIAC
__Y __N Frequent chest pains
__Y __N Palpitations
__Y __N Infection of the heart
__Y __N Other:____________

PULMONARY
__Y __N Shortness of breath
__Y __N Cough up blood
__Y __N Frequent coughing
__Y __N Wheezing
__Y __N Other:____________

OB/GYN
__Y __N History of venereal disease
__Y __N Chance of pregnancy now
__Y __N Pregnancies # _____ Births # _____
__Y __N Last menstrual period: ___________

BREAST
__Y __N Cancer
__Y __N Pain
__Y __N Massess/Lumps
__Y __N Mammogram? Date: __________.

GASTROINTESTINAL
__Y __N Abdominal pain – how long? _________
__Y __N Rectal Bleeding
__Y __N Change in bowel habits
__Y __N Constipation
__Y __N Diarrhea
__Y __N Hemorrhoids
__Y __N Rectal/anal pain, itching, burning
__Y __N Nausea/vomiting
__Y __N Change in appetite

UROLOGIC
__Y __N Increased frequency
__Y __N Dribbling
__Y __N Blood in urine
__Y __N Kidney stones
__Y __N Get up at night - how many times? _______
__Y __N Other:____________

MUSCULOSKELETAL
__Y __N Joint pain
__Y __N Joint swelling
__Y __N Muscle disorder or problem
__Y __N Other:____________

NEUROLOGIC
__Y __N Seizure disorder
__Y __N Fainting
__Y __N Numbness in arms or legs
__Y __N Paralysis

VASCULAR
__Y __N Aneurysm
__Y __N History of blood clots
__Y __N Other:____________

ENDOCRINE
__Y __N Kidney dialysis
__Y __N Diabetes

IMMUNE
__Y __N Blood transfusion
__Y __N Immunosuppression

SURGERY
__Y __N Problems with anesthesia
What? _______________
__Y __N Prolonged bleeding when cut
__Y __N Latex Allergy

OVER →

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PAST SURGICAL HISTORY: List any operations you had with approximate date and/or age of surgery.

	Date/Age		Date/Age
__Y __N Appendectomy	______________________	__Y __N Cholecystectomy/gallbladder	___________________
__Y __N Hysterectomy	______________________	__Y __N Wisdom teeth extraction	______________________
__Y __N Hernia Repair	______________________	__Y __N Tonsils/Adenoids	______________________
__Y __N C-section	______________________	__Y __N Prostate	______________________
__Y __N Tubal Ligation	______________________	__Y __N Rectal surgery	______________________

Please list any additional surgeries:

Operation: Date:

____

____

____

____

____

SOCIAL HISTORY:

Tobacco Use:

______Never used _______Current User _______Former User (when did you quit:_______________)

If current user: ______ cigarettes ______cigars ______ smokeless tobacco

How much per day:____________

How many years:______________

Alcohol Use:

_______Never used _______Current User _______Former User

If current user:

- ______ # of beer per day
- ______ # of wine/liquor servings per day
- ______ few times a year only
- ______ socially – weekly/weekends
- ______ alcoholism/abuse

FAMILY HISTORY:

Does anyone in your family (blood relatives) have:

______Y______N Colon or Rectal cancer – who? ____

______Y______N Colon polyps – who? ____

Please list any family members (parents, grandparents, siblings, children, aunts, uncles, cousins) with these conditions:

___ Diverticulitis ____________________________ ___ Heart Disease ______________________________

___ Crohn's Disease __________________________ ___ Diabetes ___________________________________

___ Ulcerative colitis _________________________ ___ Asthma ____________________________________

___ Stroke ________________________________ ___ High Blood Pressure __________________________

Cancers:

___ Breast ________________________________ ___ Prostate ___________________________________

___ Uterine _______________________________ ___ Lung ______________________________________

___ Ovarian _______________________________ ___ Liver ______________________________________

___ Stomach _______________________________ ___ Other: _____________________________________