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.

Health History

Please answer these questions concerning your health status. This information will help Dr. Roseman take better care of you. Of course, all information is confidential

Name _____ Age _____ Date of Birth _____

What is the main reason for today's visit? _____ Family Doctor's Name _____

Health Habits

Please answer each question by checking the appropriate box.

Do you...

☐ Yes ☐ No Currently smoke cigarettes?
_____packs per day_____

☐ Former Smoker ☐ Never a smoker

☐ Yes ☐ No Chew tobacco?
How much? _____

☐ Yes ☐ No Drink beer?
_____bottles per _____

☐ Yes ☐ No Drink wine?
_____oz. per _____

☐ Yes ☐ No Drink hard liquor?
_____oz. per _____

☐ Yes ☐ No Use aspirin, ibuprofen, 'arthritis medications'
How often? _____

☐ Yes ☐ No Drink beverages with caffeine
_____ cups per day

☐ Yes ☐ No On a special diet
What type? _____

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

Operations

☐ NONE

What was done? **About when?**

_____

_____

_____

Current Medications and Dose

☐ NONE

(Include all non-prescription medications)

Drug	Strength	How Often

Allergies to Medications

☐ NONE

_____

_____

_____

_____

Do you have a Latex allergy? ☐ Yes ☐ No
Do you use oxygen? ☐ Yes ☐ No
Do you have a defibrillator? ☐ Yes ☐ No

Family Health History

Do these problems run in your family? Please mark an "X" where appropriate.

	Father	Mother	Father's Father	Father's Mother	Mother's Father	Mother's Mother	Brothers	Sisters	Other
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐
Colon Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐
Colon Polyps	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ulcer Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐
Gallbladder Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ulcerative Colitis/ Crohn's	☐	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐	☐
Celiac Sprue	☐	☐	☐	☐	☐	☐	☐	☐	☐

06/2016

HERITAGE VALLEY MEDICAL GROUP

Sharon R. Roseman, MD, FACP
Practice Limited to Gastroenterology

Name:_____ Date of Birth:_____

Review of Systems

Sharon R. Roseman, MD, FACP
Practice Limited to Gastroenterology

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

Skin

☐ Y ☐ N Severe itching
☐ Y ☐ N Persistent rash
☐ Y ☐ N Changing moles
☐ Y ☐ N Psoriasis

Head

☐ Y ☐ N Severe headaches
☐ Y ☐ N Double vision
☐ Y ☐ N Glaucoma
☐ Y ☐ N Cataracts
☐ Y ☐ N Difficulty hearing
☐ Y ☐ N Ringing in ears
☐ Y ☐ N Wear hearing aid
☐ Y ☐ N Wear dentures
☐ Y ☐ N Loose teeth
☐ Y ☐ N Bleeding gums
☐ Y ☐ N Severe nosebleeds
☐ Y ☐ N Frequent sore throats
☐ Y ☐ N Persistent hoarseness

Blood

☐ Y ☐ N Blood transfusion in past 6 months
☐ Y ☐ N Prolonged bleeding from surgery
☐ Y ☐ N Anemic in past
☐ Y ☐ N Ever treated for cancer
☐ Y ☐ N Think I am at high risk for AIDS

Muscles and Joints

☐ Y ☐ N Muscle cramps
☐ Y ☐ N Muscle weakness
☐ Y ☐ N Arthritis or joint pain
☐ Y ☐ N Frequent back pain

Endocrine

☐ Y ☐ N Thyroid problem
☐ Y ☐ N Diabetes
☐ Y ☐ N Take insulin

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

Digestive Tract

☐ Y ☐ N Poor appetite
☐ Y ☐ N Nausea
☐ Y ☐ N Vomiting
☐ Y ☐ N Frequent heartburn
☐ Y ☐ N Heartburn awakens
☐ Y ☐ N Trouble swallowing
☐ Y ☐ N Hiatal hernia in past
☐ Y ☐ N Rectal bleeding
☐ Y ☐ N Rectal pain
☐ Y ☐ N Black bowel movements
☐ Y ☐ N Vomited blood
☐ Y ☐ N Ulcers in past
☐ Y ☐ N Abdominal pain
☐ Y ☐ N Diarrhea
☐ Y ☐ N Lost bowel movement/soiling
☐ Y ☐ N Constipation
☐ Y ☐ N Bowel habit unpredictable
☐ Y ☐ N Milk or lactose intolerance
☐ Y ☐ N Colon polyps in past
☐ Y ☐ N Colon cancer in past
☐ Y ☐ N Liver disease or jaundice
☐ Y ☐ N Gallstones

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

HERITAGE VALLEY MEDICAL GROUP℠

PATIENT INFORMATION

NAME: LAST FIRST MIDDLE INITIAL SEX BIRTHDATE

M F

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

S M W Sep Div

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)

☐ American/AK Indian ☐ Black/African American

☐ Asian/Pacific Islander ☐ Hispanic

☐ White ☐ Unknown/Decline

ETHNICITY (MARK ONE)

☐ Not of Hispanic Origin

☐ Hispanic Origin

☐ 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 #

HOLDER'S RELATIONSHIP TO PATIENT: Check One

☐ Self
☐ Spouse
☐ Significant Other
☐ Natural Child with financial responsibility
☐ Natural Child without financial responsibility
☐ Grandchild
☐ Other Specify:_____

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

NAME OF **SECONDARY INSURANCE CO**

INSURED'S NAME **(Subscriber of insurance)** SUBSRIBER'S BIRTHDATE

ID # OR AGREEMENT # GROUP #

EFFECTIVE DATE:

HOLDER'S RELATIONSHIP TO PATIENT: Check One

☐ Self
☐ Spouse
☐ Significant Other
☐ Natural Child with financial responsibility
☐ Natural Child without financial responsibility
☐ Grandchild
☐ Other Specify:_____

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: _____

PATIENT OR RESPONSIBLE PARTY

06/2012

Please read and sign back page

PATIENT NAME: _____ **D.O.B.**_____

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

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HERITAGE VALLEY HEALTH SYSTEM

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:

_____ _____
Patient Name (Please PRINT) *Date of Birth*

Name of Person able to obtain information on my behalf: Relationship to Patient:

1) _____ _____

2) _____ _____

3) _____ _____

4) _____ _____

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.

9/2012

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HERITAGE VALLEY HEALTH SYSTEM

Dr. Gregory B. Patrick, *Pulmonology*
Dr. Sharon R. Roseman, *Gastroenterology*

Patient Financial Policy

701 Broad Street, Suite 411
Sewickley, PA 15143
Phone: (412) 749-7160
Fax: (412) 749-7388

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.

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HERITAGE VALLEY
HEALTH SYSTEM

SHARON R. ROSEMAN, MD

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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)*

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HERITAGE VALLEY
Health System

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?

   _____