Twin Forks Gastroenterology& Hepatology, P.C.
Eyad M. Ali, M.D.

Your scheduled consultation is _____

PRIOR TO YOU APPOINTMENT PLEASE HAVE THE FOLLOWING (if applicable):

Insurance card	**Referrals**
Medical Records	**X-Rays, CAT Scans, Sonogram**
Blood Test Results	**Operative Reports**
Pathology Reports	**Medications List**

We will be happy to answer any questions you may have, and look forward to having you as a patient.

If you fail to cancel your appointment with more than 24 hours notice or do not show up at your scheduled time there is a cancellation fee of $50.

We will call to confirm your appointment two days (48 HOURS) prior

PLEASE !!! **CALL US TO CONFIRM** !!! OR
YOUR APPOINTMENT WILL BE GIVEN AWAY
You will not be seen if you show up for an appointment which you did not confirm

Leave Message On Answering Machine available 24 hours a day or email us at twinforksgastro@gmail.com at least 24 hours prior to your scheduled time or your appointment will be cancelled.

Directions

Dr. Ali's office is the second building: Suite 1

From Sunrise Highway:
Take Sunrise Hwy (RT 27) to exit 65S (Hampton Bays). Make Right at Hampton Bays Diner. After the 4th light (Wild By Nature Shopping center), continue heading West on Montauk Highway. Just past the Car Wash on the right hand side the sign on Montauk Hwy says Twin Forks Professional Center.

From Riverhead:
Take 24 all the way down to Montauk Highway (where the diner and Macy's are). Make Right at Hampton Bays Diner. After the 4th light (Wild By Nature Shopping center), continue heading West on Montauk Highway. Just past the Car Wash on the Right hand side the sign on Montauk Hwy says Twin Forks Professional Center.

332 West Montauk Highway, Suite 1
Hampton Bays, NY 11946
631 723 0600 Fax 631 723 0003

Twin Forks Gastroenterology Patient Information

1. Name_____ Date_____
(Last) (First) (Middle Initial)

2. Address_____ City_____ Zip_____

3. Home Telephone_____ Work Telephone_____ Cell: _____

4. Marital Status: ○Single ○Married ○Divorced ○Separated ○Widowed ○Domestic Partner

5. Email_____ 6. Date of Birth ___/___/___ 7. SS#_____

8. Employer Name_____ 9.Occupation_____

10. Work Address_____ City_____ Zip_____

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11. Primary Insured _____ Relation to Patient_____

Primary Insurance_____ ID#_____

Secondary Insurance_____ ID#_____

12. Social Security Number_____ 13. Date of Birth_____

14. Employer Name_____

15.Occupation_____

16. Work Address_____ City_____ Zip_____

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17. In Case of Emergency Notify _____

18. Relationship_____ Telephone_____

AUTHORIZATION FOR TREATMENT, PAYMENT & HEALTHCARE OPERATIONS

I authorize the release of my medical information for purposes of treatment, payment, and healthcare operations. Additionally, I authorize and assign any medical benefits to Twin Forks GI, PC. Its successors and assigns, or any individual it may designate for services provided.
As part of this authorization, Twin Forks GI will release HIV, drug and alcohol, and Mental Health/Psychiatric information as required by law.
I agree to pay interest at the prevailing rate for amounts 30 days past due, as well as all costs including attorney's fees, associated with the collection of any amounts due for services rendered. I understand that I am financially responsible to Twin Forks GI, its successors and assigns or any individual it may designate, for amounts owed by me in accordance with my health benefit coverage. I acknowledge that I will be responsible for all unpaid claims if I fail to provide insurance information within my health plan's filing limit for services rendered.

Signature of Patient or Parent of Minor_____ Date_____

MEDICARE AUTHORIZATION FOR TREATMENT, PAYMENT & HEALTHCARE OPERATIONS

I authorize the release of my medical information for purposes of treatment, payment, and healthcare operations. I request that payment of Authorized Medicare benefits be made either to me or on my behalf to Twin Forks GI, PC. For services furnished to me by the providers. I authorize any holder of my medical information to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine benefits for related services rendered.

Signature of Patient _____ Date_____

Notice of Privacy ☐ **Accepted** ☐ **Refused** _____
Signature of Patient or Parent of Minor Date

May Release protected health information to: _____
Name Relationship

Twin Forks Gastroenterology& Hepatology, P.C.
Eyad M. Ali, M.D.

New Patient History

Please answer the following questions.

Name_____ Date of Birth_____ Sex_____
Occupation_____ Marital Status_____

Primary Care Physician_____ Phone#_____

Who may we thank for referring you?_____

WHAT IS YOUR MAIN COMPLAINT AND REASON FOR COMING HERE?

GASTROINTESTINAL HISTORY (check all that apply)

Difficulty Swallowing ☐	Gas ☐	Recent Change in Bowel Habits ☐
Heartburn ☐	Diarrhea ☐	Diverticulosis ☐
Regurgitation ☐	Constipation ☐	Gallbladder Disease ☐
Abdominal Pain ☐	Rectal Bleeding ☐	Pancreatitis ☐
Excessive Burping ☐	Hemorrhoids ☐	Liver Disease ☐
Bloating ☐	Colon Cancer or Polyps ☐	Jaundice ☐

MEDICAL HISTORY (List all operations you have had and approximate dates)

List all major illnesses (example: high blood pressure, asthma, heart disease, diabetes, etc.)

Previous hospitalizations (when and why)

Allergies_____

What medications are you currently taking? (including over the counter medications, herbs and aspirin)

Have you ever had: GI Series ☐ Barium Enema ☐ Gallbladder X-Rays or Sonogram ☐
Sigmoidoscopy ☐ Colonoscopy ☐ Endoscopy ☐

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PERSONAL HISTORY

Do you have children? _____ If so how many?_____

Do you smoke tobacco? (how much and if you stopped when)_____

Alcohol: Do you drink- Never ☐ Once a week ☐ More than 3 days per week ☐

Have you ever had a drinking problem?_____

Do you or have you used illicit drugs?_____ If so which ones_____

FAMILY HISTORY Is there any history in your family of (check all that apply)

Colon/Rectal Cancer ☐ Colon Polyps ☐ Ulcerative Colitis ☐ Crohn's Disease ☐ Breast Cancer ☐

Liver Disease ☐ Other Cancer ☐ Diabetes ☐

Heart Disease ☐ Pancreatitis ☐ Bleeding Disorder ☐

Other:_____

REVIEW OF SYSTEMS (Check all that apply)

CONSTITUTIONAL Weight Loss ☐ Fever ☐ Extreme Fatigue ☐ Sleep Disturbances ☐ Loss of Appetite ☐

Explain:_____

_____

EYES, EARS, NOSE, MOUTH & THROAT

Eye Problems ☐ Ear Problems ☐ Sores in Mouth ☐ Nosebleeds ☐ Bleeding Gums ☐

Explain:_____

_____

RESPIRATORY Shortness of Breath ☐ Cough ☐ Wheezing ☐ Lung Disease ☐

Explain:_____

_____

CARDIOVASCULAR Heart Disease ☐ Chest Pain ☐ Palpitations ☐ Heart Murmur ☐

Explain:_____

_____

ENDOCRINE Thyroid Disease ☐ Excessive Thirst or Urination ☐ Heat or Cold Intolerance ☐ Diabetes ☐

Explain:_____

_____

GENITOURINARY Difficulty Urinating ☐ Kidney or Bladder Disease ☐ Stones ☐ Blood in Urine ☐

Explain:_____

MEN: Prostate Problems ☐ **WOMEN:** Abnormal Menstrual Periods/Menopause ☐

MUSCULOSKELETAL Arthritis ☐ Difficulty Walking ☐ Neck or Back Problems ☐

Explain:_____

NEUROLOGICAL Paralysis ☐ Stroke ☐ Seizure ☐ Blackouts ☐ Convulsions ☐

Explain:_____

_____

PSYCHIATRIC Depression ☐ Anxiety ☐ Psychiatric Hospitalization ☐ Drug Addiction ☐ Other ☐

Explain:_____

_____

HEMATOLOGIC Easy Bruising/ or Bleeding ☐ Enlarged Spleen/Enlarged Lymph Nodes ☐

Explain:_____

Patient Name:

Date of Birth:

To Whom It May Concern:

Please allow Twin Forks Gastroenterology and Hepatology, PC. (TIN# 34-1975445) appeal any and all claims on my behalf. Please allow all future correspondence and phone calls to be handled directly between Twin Forks Gastroenterology and Hepatology, PC. and my insurance company. Thank you very much.

Please allow Twin Forks Medical, PC. (TIN# 45-1616309) appeal any and all claims on my behalf. Please allow all future correspondence and phone calls to be handled directly between Twin Forks Medical, PC. and my insurance company. Thank you very much.

Sincerely,

_____ _____

Patient Name Patient Signature

_____

Date of Signature

Twin Forks Gastroenterology& Hepatology, P.C.
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OFFICE POLICIES

1. If you cancel your **office visit** appointment with less than 24 hours notice or do not show up at your scheduled time there is a cancellation fee of $50.

2. If you cancel your **procedure** appointment with less than 48 hours notice or do not show up at your scheduled time there is a cancellation fee of $100.

3. Medical Records will be provided upon request for $0.75/page.

4. If Dr. Ali recommends that you have a procedure, you must schedule your procedure within 3 months of your consultation; otherwise, you will need another office visit to be cleared for anesthesia.

5. There is a $25 bounce check fee. There is a 3% convenience fee on all credit card payments.

6. I acknowledge that I will be responsible for all unpaid claims if I fail to provide insurance information within my plan's filing limit for services rendered.

7. All billing statements for outstanding balances shall be issued to patients at the end of the calendar month. 30 days after statements have been issued, remaining outstanding balances from those statements shall incur an interest fee of 12% compounded monthly. 90 days after billing statements have been issued; remaining outstanding balances from those statements shall be assigned to a debt collection agency.

8. I agree to reimburse TFGI the fees of any collection agency, which may be based on a percentage at a maximum of 33% of the debt, and all costs, and expenses, including reasonable attorney's fees, we incur in such collection efforts.

9. I am aware that Twin Forks may contact me via email or text message for appointment/recall notifications and billing statements.

I have read and understand these policies.

_____

Print Name

_____

Signed Date