Wisconsin Colon & Rectal Clinic

Thank you for choosing Wisconsin Colon & Rectal Clinic for your healthcare needs. We look forward to meeting you. Please arrive at least 15 minutes prior to your appointment time to register for your visit.

To make your initial visit to our office more efficient, the patient registration forms necessary for your appointment are included with this letter. Please fill them out **prior** to your appointment and bring them with you on the day of your visit. **Incomplete forms will delay your scheduled appointment time.** In addition, please remember to bring the following:

- Your insurance card(s).
- Co-payment(s) may be required by your insurance plan. For your convenience, we accept cash, checks, Mastercard, Visa, and Discover cards.
- The name of the hospital of choice under your insurance plan.
- If your insurance plan requires a referral, please make arrangements with your primary care provider prior to your appointment. If a referral has not been received by the date of your appointment, the appointment may need to be rescheduled.
- Other ____

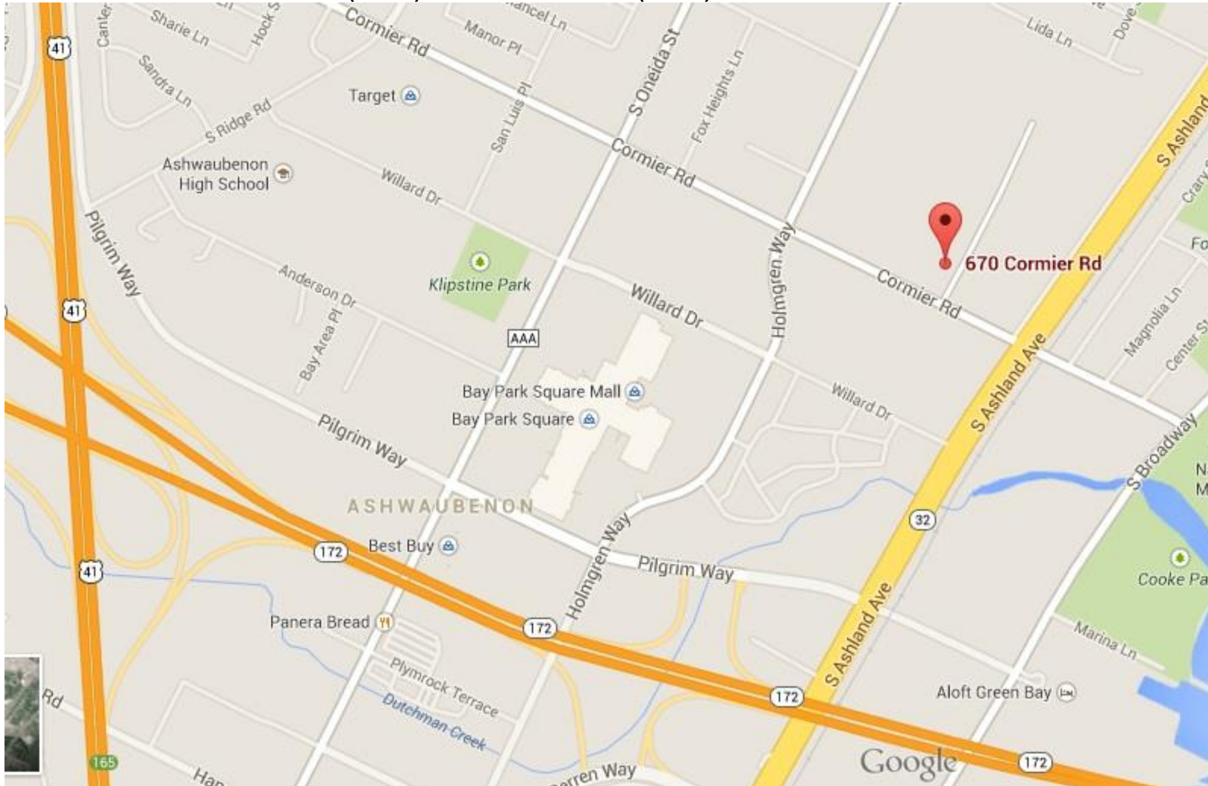
If you have any questions, please feel free to call us.

Sincerely,

The Staff of Wisconsin Colon & Rectal Clinic

Wisconsin Colon & Rectal Clinic

A Division of NEW Surgical Associates
670 Cormier Road
Green Bay, WI 54304
(920) 494-9685 or (800) 453-2682



From the East on Hwy. 172:
On Hwy. 172, take the Oneida St/Ashland Ave. Exit. Turn right on to Pilgrim Way. Turn left on Ashland Ave. Turn left on Cormier Rd. Our office is on the right hand side.

From the UP:
Take Hwy. 41 S. to the Lombardi Ave Exit, #167. Turn left on Lombardi Ave. Turn right on Oneida St. Turn left on Cormier Rd. Our office is on the left hand side.

From the Fox Valley:
Take Hwy. 41 N. to Green Bay. Take Oneida St/Waube Lane Exit, #164. Turn right on Oneida St. Turn right on Cormier Rd. Our office is on the left hand side.

From the West on Hwy. 172:
Take the Oneida St/Ashland Ave. Exit. Turn left on Vanderperren Way. Turn left on Ashland Ave. Turn left on Cormier Rd. Our office is on the right hand side.

Wisconsin Colon & Rectal Clinic

Green Bay Vein Center

NEW Surgical Associates Patient Registration

Full **Legal** Name ____ DOB ____/_____/________

☐ Male ☐ Female ☐ Single ☐ Married ☐ Divorced/Separated ☐ Widowed ☐ Partner SSN# _______-_____-______

Street ________________________ Apt# ________ City ____________________ State ____ Zip _________

Employer _________________________________ Email ___________________________________

Spouse's Name ____ Phone # (_____) ______ - ________

Emergency Contact (if not spouse) _________________________________ Phone # (_____) ______ - ________.

If patient is a minor or has a legal guardian:

Name of Parent / Guardian _____________________________________ Phone # (_____) ______ - ________

Consent to Allow Access to Protected Health Information/Contact Permission: If we need to contact you for matters including but not limited to test results, appointment reminders, payment issues, coverage of services and benefit determination, we will attempt to reach you by the method you specify:

BEST FORM OF CONTACT: ☐ Home # ☐ Cell # ☐ Work # Best time to call ______________________

Home Ph# (_______) _______ - __________ May we identify ourselves and leave a message? ☐ Yes ☐ No

Cell Ph# (_______) _______ - __________ May we identify ourselves and leave a message? ☐ Yes ☐ No

Work Ph# (_______) _______ - __________ May we identify ourselves and leave a message? ☐ Yes ☐ No

INSURANCE INFORMATION

PRIMARY INSURANCE ☐ **None** Relationship to PATIENT ☐ Self ☐ Spouse ☐ Other_______________

Insurance company name ____

Subscriber Name _____________________________________ Subscriber DOB ______/________/__________

Policy ID # ____ Group # ______________________________

SECONDARY INSURANCE ☐ **None** Relationship to PATIENT ☐ Self ☐ Spouse ☐ Other_______________

Insurance company name ____

Subscriber Name _____________________________________ Subscriber DOB ______/________/__________

Policy ID # ____ Group # ______________________________

Wisconsin Colon & Rectal Clinic

Green Bay Vein Center

NEW Surgical Associates Patient Registration

Consent to Access of Protected Health Information: The following are family members or representatives to whom we may disclose your protected health information, such as, but not limited to, test results, appointment reminders, payment issues, benefit determination, and coverage of services. Please indicate any restrictions on the type of disclosures to be made to these representatives. You may revoke consent at any time by giving written notice.

Name _________________________________ Phone # (_____) _____ - _______ Relationship___________________

Any restrictions? ____

Name _________________________________ Phone # (_____) _____ - _______ Relationship___________________

Any restrictions? ____

Acknowledgement of Receipt of Notice of Privacy Practices: I have received a copy of NEW Surgical Associates Notice of Privacy Practices, which describes how NEW Surgical Associates may use and disclose my protected health information, certain restrictions on the use and disclosure, and rights I may have regarding my protected health information.

Initials __________

Consent to access Relay Health for Medication/Allergy Information: I hereby give NEW Surgical Associates permission to access RelayHealth (provides clinical connectivity to physicians, patient, hospitals and more using innovative health information technology) to import medication/allergy information. Initials __________

Billing Insurance: I understand my insurance is billed as a courtesy, and I acknowledge that I am financially responsible for all charges whether or not they are covered by insurance. If it becomes necessary to effect collections on any amount owed for services rendered, I agree to pay for all expenses, including reasonable attorney fees. I authorize the release of information concerning my/my child's health care, advice & treatment provided for the purpose of evaluating and administering claims for insurance benefits. I authorize payment of surgical or medical benefits to NEW Surgical Associates.

Initials _________

Consent to Evaluation and Treatment: I agree and give consent for NEW Surgical Associates to furnish medical care and treatment considered necessary and proper in diagnosing or treating my medical condition. This includes but is not limited to examination, diagnostics, photographs, and requests for medical record information.

Signature of Patient or Representative: ____Date: ____/_____/_____

Patient Representative Relationship: ____

Patient Name: ______________________________ **DOB**: ____________ **Today's Date**: __________

Pharmacy: ______________________________ **Pharmacy Phone**: ____________________

Pharmacy Address: ____

Current Medications (prescription, over-the-counter, herbal, vitamins)	Dose/Strength	Frequency/ When Taken	Ordering Doctor	What It's Taken For

Allergies

Medication Allergies

Drug	Reaction

Environmental Allergies (food, tape, latex, etc.)

Drug	Reaction

Additional information: ____