



Patient Registration Form

Please Complete All Information

Appointment Date: _____

Patient Information

Last Name: _____ First Name: _____ M.I.: _____

Date of Birth: ____/____/____ Age: ____ SSN: ____ - ____ - ____ Sex: ____ Marital Status: _____

Race: _____ Ethnicity: _____ Pref. Language: _____

Address: _____

Email: _____ Home Phone: _____ Cell Phone: _____

Occupation: _____ Employer: _____

Employer Address: _____ Employer Phone: _____

Primary Care Physician: _____ Referring Physician: _____

Pharmacy Name: _____ Pharmacy Address: _____

Pharmacy Phone: _____ Rx Card Number: _____

Emergency Contact: _____ **Relationship to Patient:** _____

Emergency Contact Primary Phone: _____ Secondary Phone: _____

Primary Insurance Please provide a copy of insurance card.

Insurance Carrier: _____ Policy ID#: _____ Group #: _____

Insurance Effective Date: ____/____/____ Insurance Co Phone: _____

Address: _____

Subscriber's Name: _____ Relationship to Patient: _____

Address (if different from patient): _____ Subscriber's Phone: _____

Subscriber's Date of Birth: ____/____/____ SSN: ____ - ____ - ____ Subscriber's Employer: _____

Secondary Insurance Please provide a copy of insurance card.

Insurance Carrier: _____ Policy ID#: _____ Group #: _____

Insurance Effective Date: ____/____/____ Insurance Co Phone: _____

Address: _____

Subscriber's Name: _____ Relationship to Patient: _____

Signature of Patient or Guardian

Date



Consent for Use and Disclosure of Protected Health Information (PHI)**Use and Disclosure of PHI**

Your PHI will be used by Allied Digestive Health, or disclosed to others, for the purpose of treatment, obtaining payment, or supporting the day to day healthcare operations of the practice.

Requesting a restriction on the Use or Disclosure of your information

You may request a restriction on the use or disclosure of your protected health information. Allied Digestive Health may agree to restrict the use or disclosure of your protected health information. If ADH agrees to your request, the restriction will be binding on practice as a whole. Unauthorized use and disclosure of PHI is a violation of an agreed upon restriction and will be a violation of federal privacy standards.

I give consent to be contacted in the following manner:

Primary Telephone # _____

- € Do not call this number
- € Ok to leave message to **call back only**
- € Ok to leave message **with results and detailed information, including billing.**

Secondary Phone # _____

- € Do not call this number
- € Ok to leave message to **call back only**
- € Ok to leave message **with results and detailed information, including billing.**

Other persons authorized to receive my health information:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Revocation of Consent

You may revoke this consent in the use and disclosure of you Protected Health Information at any time. You may revoke this consent in writing. Any use of disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

I have reviewed this consent form and hereby give my permission to Allied Digestive Health to use and disclose my Protected Health Information in accordance with these guidelines.

Signature of Patient or Patient Representative

_____/_____/_____
Date

Printed Name of Patient or Patients Representative



The Gastroenterology Group of Northern New Jersey

Patient Financial Responsibility Statement

Thank you for choosing our practice for your healthcare needs. It is our goal to provide you with the highest quality healthcare services as possible. We ask that you please read and understand your financial responsibilities prior to receiving services.

Patient Name: _____

1. I understand that I am responsible for knowing the policy provisions and rules of my insurance coverage(s) and that I am solely responsible for obtaining any necessary referrals prior to my appointment. Failure to obtain and present a valid referral may result in my being financially responsible for all services provided.
Please note: a Doctor's Prescription is NOT a valid Referral.
2. I understand that I am financially responsible for any amount not covered by my insurance including, but not limited to, co-pays, co-insurances, deductibles and non-covered services.
3. I understand that if I do not have valid medical insurance, I am financially responsible for all fees for provision of medical services and that, unless other arrangements have been made in advance, payment of these fees is expected in full at the time services are rendered.
4. I understand that failure to remit payment for any amounts deemed patient responsibility may result in my account being referred for collection activity and that I will be financially responsible for any additional fees incurred as a result.
5. I understand that any appointments missed, but not cancelled within twenty-four (24) hours, will result in my being charged a Missed Appointment Fee of \$35 per missed office visit and \$300 per missed procedure.
6. I understand that I will be charged \$35 for any check returned by my bank for any reason.

BY MY SIGNATURE BELOW, I ACKNOWLEDGE THAT I UNDERSTAND AND AGREE TO THESE TERMS:

Signature of Patient or Guardian

Today's Date



Assignment of Benefits

I hereby authorize any insurance carrier, including Medicare, to make payment directly to Allied Digestive Health for any services rendered to me or my covered dependents of any amounts otherwise payable to me toward the reimbursement of any medical expenses incurred at this facility. **I understand that I am financially responsible for payment of all services regardless of any payment issued by my insurance or not.** A photocopy of this authorization shall be considered as effective and valid as the original.

Signature of Patient or Guardian

Today's Date

Release of Medical Records and Information

I hereby authorize the release of any Protected Healthcare Information (PHI) to any involved insurance company, or their authorized third parties involved in my case unless I have specifically instructed otherwise.

Signature of Patient or Guardian

Today's Date

Medicare Patients ONLY

I understand that Medicare may not cover this service. I have been given a Medicare Advanced Beneficiary Notice of Non-Covered Service (ABN) which explains my options for procedures that may not be covered by Medicare.

Signature of Patient or Guardian

Today's Date

Colonoscopy & Endoscopy Patients ONLY

I understand that Allied Digestive Health's bills for its physicians ONLY: In addition, I may be responsible for, and receive a separate bill (when applicable) from:

1. The Hospital or Endoscopy Center for any facility fees.
2. The Laboratory / Pathologist for any tissue/biopsy testing.
3. The Anesthesiologist for provision of any anesthesia.

I further understand that the final determination of whether an exam is considered "screening" or "diagnostic" cannot be made until the results are complete. I have received and understand a copy of "Colonoscopy: Screening, Surveillance or Diagnostic. I acknowledge that the physician's determination is final and will not be changed for the purpose of reconsideration / overturning of insurance decisions.

Signature of Patient or Guardian

Today's Date



The Gastroenterology Group of Northern New Jersey

**PATIENT ACKNOWLEDGEMENT OF
THE NOTICE OF PRIVACY PRACTICES
AND CONSENT FOR USE AND DISCLOSURE OF
PERSONAL HEALTH INFORMATION**

Print Patient's Name

Date

I, _____, acknowledge that I
(Signature of Patient or Parent or Legal Guardian)

Have either received a copy of this office's NOTICE OF PRIVACY PRACTICES or that
Allied Digestive Health's NOTICE OF PRIVACY PRACTICES was made available to me
to receive.

I, _____, consent to the use and disclosure of
(Signature of Patient or Parent or Legal Guardian)

My personal health information by your office for Treatment, Billing / Payment and Health care
Operations as outlined in the NOTICE OF PRIVACY PRACTICES.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

**PLEASE REVIEW IT CAREFULLY
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US**

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you, or to family and friends you approve.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. You also have the right to request restrictions on disclosure of PHI (Personal Health Information), or alternative means of communication to ensure privacy.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law or national security activities.

Abuse or Neglect: We may disclose your health information to appropriate authorities when we suspect abuse or neglect.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (Such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information with limited exceptions. If you request copies, we will charge you a reasonable fee to locate and copy your information, and postage if you want the copies mailed to you.

Amendment: You have the right to request that we amend your health information.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us with the U.S. Department of Health and Human Services. A Privacy/Contact Officer has been designated for this office. The Privacy Officer can be contacted by simply contacting the office and asking to speak to the Practice Administrator who serves as the Privacy Officer.