



**MONMOUTH**  
 —DIGESTIVE HEALTH—  
**STEVEN A. GORCEY MD**

145 Wyckoff Road Eatontown New Jersey 07724

T 732-597-7333 F 732 597 7484

[WWW.Monmouthdigestivehealth.com](http://WWW.Monmouthdigestivehealth.com)

Email: [GorceyMD@Monmouthdigestivehealth.com](mailto:GorceyMD@Monmouthdigestivehealth.com)

Please complete all paperwork prior to your scheduled appointment, or plan to arrive 45 minutes before your scheduled appointment time to complete these forms, so that the doctor can see you in a punctual fashion.

Patient Name:

MRN \_\_\_\_\_

Scheduled Appointment Time

Please make every effort to arrive 30 minutes early

Please be sure to bring the following:

Completed registration packet

Photo ID such as a driver's license

Insurance and prescription cards

List of your medications

Your Co pay (Check, Cash or Credit card) if applicable

Referral if required by your insurance carrier

Medical records including hospital and office visits. Please download medical record release form from [WWW.Monmouthdigestivehealth.com](http://WWW.Monmouthdigestivehealth.com)

**Insurance:** Please be aware you will be billed for all unmet in network deductibles and copays as outlined by your insurance benefits.

**Cancellations:** Other than for a documented emergency, **all cancellations** must be reported 24 hours prior to the scheduled visit time in order that we can fill that time slot with another patient.

**Please be courteous about this .** As of now we do not charge a penalty fee for cancellations, and hope not to be forced to enact one in the future.

We are looking forward to seeing you



## Patient Information

Last Name First Name MI Age

D.O.B Sex Marital status SSN Ethnicity

Address

Home Phone Cel Phone Email

Who Referred You Primary physician

Occupation Employer

Employer Address Employer Phone

Emergency contact relationship Phone

Pharmacy Name Pharmacy Address

Pharmacy Phone

### Primary Insurance

Carrier Policy ID# Group#

Insurance Phone Address

Subscriber's Name Relationship to Patient

Subscriber's Address Subscriber's Phone

Subscriber's DOB Subscriber's SSN Employer

### Secondary Insurance

Carrier Policy ID# Group#

Insurance Phone Address

Subscriber's Name Relationship to Patient

Subscriber's Address Subscriber's Phone

Subscriber's DOB Subscriber's SSN Employer

**I consent to obtaining a history of my medications from a pharmacy or online database (PDMP)**

## HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The terms of this Notice of Privacy Practices ("Notice") apply to Monmouth Digestive Health LLC, its affiliates and its employees. Monmouth Digestive Health will share protected health information of patients as necessary to carry out treatment, payment, and health care operations as permitted by law. We are required by law to maintain the privacy of our patients' protected health information and to provide patients with notice of our legal duties and privacy practices with respect to protected health information. We are required to abide by the terms of this Notice for as long as it remains in effect. We reserve the right to change the terms of this Notice as necessary and to make a new notice of privacy practices effective for all protected health information maintained by [Practice Name]. We are required to notify you in the event of a breach of your unsecured protected health information. We are also required to inform you that there may be a provision of state law that relates to the privacy of your health information that may be more stringent than a standard or requirement under the Federal Health Insurance Portability and Accountability Act ("HIPAA"). A copy of any revised Notice of Privacy Practices or information pertaining to a specific State law may be obtained by mailing a request to the Privacy Officer at the address below.

### USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION:

**Authorization and Consent:** Except as outlined below, we will not use or disclose your protected health information for any purpose other than treatment, payment or health care operations unless you have signed a form authorizing such use or disclosure. You have the right to revoke such authorization in writing, with such revocation being effective once we actually receive the writing; however, such revocation shall not be effective to the extent that we have taken any action in reliance on the authorization, or if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

**Uses and Disclosures for Treatment:** We will make uses and disclosures of your protected health information as necessary for your treatment. Doctors and nurses and other professionals involved in your care will use information in your medical record and information that you provide about your symptoms and reactions to your course of treatment that may include procedures, medications, tests, medical history, etc.

**Uses and Disclosures for Payment:** We will make uses and disclosures of your protected health information as necessary for payment purposes. During the normal course of business operations, we may forward information regarding your medical procedures and treatment to your insurance company to arrange payment for the services provided to you. We may also use your information to prepare a bill to send to you or to the person responsible for your payment.

**Uses and Disclosures for Health Care Operations:** We will make uses and disclosures of your protected health information as necessary, and as permitted by law, for our health care operations, which may include clinical improvement, professional peer review, business management, accreditation and licensing, etc. For instance, we may use and disclose your protected health information for purposes of improving clinical treatment and patient care.

**Individuals Involved In Your Care:** We may from time to time disclose your protected health information to designated family, friends and others who are involved in your care or in payment of your care in order to facilitate that person's involvement in caring for you or paying for your care. If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited protected health information with such individuals without your approval. We may also disclose limited protected health information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.

**Business Associates:** Certain aspects and components of our services are performed through contracts with outside persons or organizations, such as auditing, accreditation, outcomes data collection, legal services, etc. At times it may be necessary for us to provide your protected health information to one or more of these outside persons or organizations who assist us with our health care operations. In all cases, we require these associates to appropriately safeguard the privacy of your information.

**Appointments and Services:** We may contact you to provide appointment updates or information about your treatment or other health-related benefits and services that may be of interest to you. You have the right to request and we will accommodate reasonable requests by you to receive communications regarding your protected health information from us by alternative means or at alternative locations. For instance, if you wish appointment reminders to not be left on voice mail or sent to a particular address, we will accommodate reasonable requests. With such request, you must provide an appropriate alternative address or method of contact. You also have the right to request that we not send you any future marketing materials and we will use our best efforts to honor such request. You must make such requests in writing, including your name and address, and send such writing to the Privacy Officer at the address below.

**Research:** In limited circumstances, we may use and disclose your protected health information for research purposes. In all cases where your specific authorization is not obtained, your privacy will be protected by strict confidentiality requirements applied by an Institutional Review Board which oversees the research or by representations of the researchers that limit their use and disclosure of your information.

**Fundraising:** We may use your information to contact you for fundraising purposes. We may disclose this contact information to a related foundation so that the foundation may contact you for similar purposes. If you do not want us or the foundation to contact you for fundraising efforts, you must send such request in writing to the Privacy Officer at the address below.

**Other Uses and Disclosures:** We are permitted and/or required by law to make certain other uses and disclosures of your protected health information without your consent or authorization for the following:

- Any purpose required by law;
- Public health activities such as required reporting of immunizations, disease, injury, birth and death, or in connection with public health investigations;
- If we suspect child abuse or neglect; if we believe you to be a victim of abuse, neglect or domestic violence;
- To the Food and Drug Administration to report adverse events, product defects, or to participate in product recalls;
- To your employer when we have provided health care to you at the request of your employer;
- To a government oversight agency conducting audits, investigations, civil or criminal proceedings;
- Court or administrative ordered subpoena or discovery request;
- To law enforcement officials as required by law if we believe you have been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law;
- To coroners and/or funeral directors consistent with law;
- If necessary to arrange an organ or tissue donation from you or a transplant for you;
- If you are a member of the military, we may also release your protected health information for national security or intelligence activities; and
- To workers' compensation agencies for workers' compensation benefit determination



## DISCLOSURES REQUIRING AUTHORIZATION:

**Psychotherapy Notes:** We must obtain your specific written authorization prior to disclosing any psychotherapy notes unless otherwise permitted by law. However, there are certain purposes for which we may disclose psychotherapy notes, without obtaining your written authorization, including the following: (1) to carry out certain treatment, payment or healthcare operations (e.g., use for the purposes of your treatment, for our own training, and to defend ourselves in a legal action or other proceeding brought by you), (2) to the Secretary of the Department of Health and Human Services to determine our compliance with the law, (3) as required by law, (4) for health oversight activities authorized by law, (5) to medical examiners or coroners as permitted by state law, or (6) for the purposes of preventing or lessening a serious or imminent threat to the health or safety of a person or the public.

**Genetic Information:** We must obtain your specific written authorization prior to using or disclosing your genetic information for treatment, payment or health care operations purposes. We may use or disclose your genetic information, or the genetic information of your child, without your written authorization only where it would be permitted by law.

**Marketing:** We must obtain your authorization for any use or disclosure of your protected health information for marketing, except if the communication is in the form of (1) a face-to-face communication with you, or (2) a promotional gift of nominal value.

**Sale of Protected Information:** We must obtain your authorization prior to receiving direct or indirect remuneration in exchange for your health information; however, such authorization is not required where the purpose of the exchange is for:

- Public health activities;
- Research purposes, provided that we receive only a reasonable, cost-based fee to cover the cost to prepare and transmit the information for research purposes;
- Treatment and payment purposes;
- Health care operations involving the sale, transfer, merger or consolidation of all or part of our business and for related due diligence;
- Payment we provide to a business associate for activities involving the exchange of protected health information that the business associate undertakes on our behalf (or the subcontractor undertakes on behalf of a business associate) and the only remuneration provided is for the performance of such activities;
- Providing you with a copy of your health information or an accounting of disclosures;
- Disclosures required by law;
- Disclosures of your health information for any other purpose permitted by and in accordance with the Privacy Rule of HIPAA, as long as the only remuneration we receive is a reasonable, cost-based fee to cover the cost to prepare and transmit your health information for such purpose or is a fee otherwise expressly permitted by other law; or Any other exceptions allowed by the Department of Health and Human Services

## RIGHTS THAT YOU HAVE REGARDING YOUR PROTECTED HEALTH INFORMATION:

**Access to Your Protected Health Information:** You have the right to copy and/or inspect much of the protected health information that we retain on your behalf. For protected health information that we maintain in any electronic designated record set, you may request a copy of such health information in a reasonable electronic format, if readily producible. Requests for access must be made in writing and signed by you or your legal representative. You may obtain a "Patient Access to Health Information Form" from the front office person. You will be charged a reasonable copying fee and actual postage and supply costs for your protected health information. If you request additional copies you will be charged a fee for copying and postage.

**Amendments to Your Protected Health Information:** You have the right to request in writing that protected health information that we maintain about you be amended or corrected. We are not obligated to make requested amendments, but we will give each request careful consideration. All amendment requests, must be in writing, signed by you or legal representative, and must state the reasons for the amendment/correction request. If an amendment or correction request is made, we may notify others who work with us if we believe that such notification is necessary. You may obtain an "Amendment Request Form" from the front office person or individual responsible for medical records.

**Accounting for Disclosures of Your Protected Health Information:** You have the right to receive an accounting of certain disclosures made by us of your protected health information after April 14, 2003. Requests must be made in writing and signed by you or your legal representative. "Accounting Request Forms" are available from the front office person or individual responsible for medical records. The first accounting in any 12-month period is free; you will be charged a fee for each subsequent accounting you request within the same 12-month period. You will be notified of the fee at the time of your request.

**Restrictions on Use and Disclosure of Your Protected Health Information:** You have the right to request restrictions on uses and disclosures of your protected health information for treatment, payment, or health care operations. We are not required to agree to most restriction requests, but will attempt to accommodate reasonable requests when appropriate. You do, however, have the right to restrict disclosure of your protected health information to a health plan if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law, and the protected health information pertains solely to a health care item or service for which you, or someone other than the health plan on your behalf, has paid [Practice Name] in full. If we agree to any discretionary restrictions, we reserve the right to remove such restrictions as we appropriate. We will notify you if we remove a restriction imposed in accordance with this paragraph. You also have the right to withdraw, in writing or orally, any restriction by communicating your desire to do so to the individual responsible for medical records.

**Right to Notice of Breach:** We take very seriously the confidentiality of our patients' information, and we are required by law to protect the privacy and security of your protected health information through appropriate safeguards. We will notify you in the event a breach occurs involving or potentially involving your unsecured health information and inform you of what steps you may need to take to protect yourself.

**Paper Copy of this Notice:** You have a right, even if you have agreed to receive notices electronically, to obtain a paper copy of this Notice. To do so, please submit a request to the Privacy Officer at the address below.

**HIPAA NOTICE OF PRIVACY PRACTICES- page 3**

**Complaints:** If you believe your privacy rights have been violated, you can file a complaint in writing with the Privacy Officer. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services at the below address. There will be no retaliation for filing a complain

**Office for Civil Rights Department of HHS  
Jacob Javits Federal Building 26 Federal Plaza - Suite 3312  
New York, NY 10278  
Voice Phone (212) 264-3313 FAX (212) 264-3039  
TDD (212) 264-2355**

**For Further Information:** If you have questions, need further assistance regarding or would like to submit a request pursuant to this Notice, you may contact the Monmouth Digestive Health Privacy Officer by phone at (732)-597-7333 or at the following address: 145 Wyckoff Road Suite 201 Eatontown NJ 07724.

This Notice of Privacy Practices is also available on our Monmouth Digestive Health web page at [www.Monmouthdigestivehelth.com](http://www.Monmouthdigestivehelth.com) under "Forms"/ Registration





# HIPAA Compliance Patient Consent Form

## Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

This notice contains a patient’s rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but we shall in fact honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive

Protected health information may be disclosed or used for treatment, payment or healthcare operations.

**By signing this form, I understand that:**

The practice reserves the right to change the privacy policy as allowed by law

The practice has the right to restrict the use of the information

The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease

May we Phone Email or Text your cell phone to confirm appointments (check box in front if **OK**)

May we leave a message on your Answering Machine Email Cell Phone as a text (Check if OK)

May we report results of testing over the phone Via Email leave a message (check if OK)

**I give permission to discuss my medical condition with:**

Relationship:

This consent was signed by: NAME

Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_



### **Agreement of Financial Responsibility**

**Thank you for choosing Monmouth Digestive Health as your health care provider. We are committed to providing quality care and service to all of our patients. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment.**

**Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are rendered. We accept cash, check, credit cards, and pre-approved insurance for which we are a contracted provider.**

**It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company.**

**We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.**

**If we have a contract with your insurance company we will bill your insurance company first, less any copayment(s) or deductible(s), and then bill you for any amount determined to be your responsibility. This process generally takes 45-60 days from the time the claim is received by the insurance company.**

**If we do not contract with your insurance company, you will be expected to pay for all services rendered at the end of your visit. We will provide you with a statement that you can submit to your insurance company for reimbursement.**

**Proof of payment and photo ID are required for all patients. We will ask to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.**

**Please understand some insurance coverages have Out-of-Network benefits that have co-insurance charges, higher co-payments and limited annual benefits. If you receive services are part of an Out-of-Network benefit, your portion of financial responsibility may be higher than the In- Network rate.**

**I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.**

**Name of Patient/Responsible Party**

**Relation to  
Patient**

**Signature responsible party \_\_\_\_\_**

**Date**



## Assignment of benefits

Name of insured

I request that payment of authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, be made on my behalf to the practice listed below for any services provided to me by the organization. I expressly assign all my rights in and to such insurance benefits directly to *Monmouth Digestive Health LLC* and authorize *Monmouth Digestive Health LLC* to endorse any and all drafts on my behalf, issued pursuant to this assignment, for the benefit of *Monmouth Digestive Health LLC*

I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to the organization, the Health Care Financing Administration, my insurance carrier or other medical entity. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance company or other entity if requested. The original authorization will be kept on file by the organization.

I understand that I am financially responsible to the practice for any charges not covered by health care benefits. It is my responsibility to notify the practice of any changes in my health care coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for product received.

In certain circumstances, insurance company may send check for services provided directly to the patient or the guarantor. In such cases, the patient and the guarantor agrees to endorse and forward such a check to *Monmouth Digestive Health LLC* If the patient deposits such a check into a personal account, the patient and guarantor agrees to immediately send a check for the equivalent amount to *Monmouth Digestive Health LLC*

**Monmouth Digestive Health LLC.**

145 Wyckoff Road Suite 201

Eatontown, NJ 07724

Name of person signing below (print) :

Relationship to insured:

Signature of Insured or Parent/Guardian: \_\_\_\_\_

Date: