



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 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: