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BOARD CERTIFIED IN
GASTROENTEROLOGY & HEPATOLOGY

365 Broad Street Red Bank, New Jersey 07701
T: 732-842-4294 F: 732-548-7408 www.rbgastro.com

Patient Name:____ MRN #:______________

Appointment Date:________________ /______________ /____ / ________
Day of the Week Month Day Year

Time of Appointment: _____________ Suggested Arrival Time: ___________
30 min. prior to appointment time

Dear Valued Patient,
In order for us to process your visit in a timely manner, it is necessary that you ***complete your paperwork*** prior to your arrival on the day of your appointment.

Please bring the following:

☐ Completed Paperwork

☐ Your Insurance Card

☐ Your Rx Card

☐ Your Driver's License for verification purposes

☐ Your Co-Pay, if applicable, is due at the time of service

☐ Referral if needed

☐ Blood Work / Hospital Stays / CT Scan / MRI Scan / Ultrasound / any other pertinent information that will assist in our physician providing you with the best care

Without these documents, we may not be able to provide you with service.

INSURANCE
We participate with most insurances, however, it is best that you verify with your insurance company if we are In-Network with your insurance carrier (we are listed as division of Allied Digestive Health with the insurance carriers), or if you have out-of-network benefits where you would pay for your office visit and the insurance company will reimburse you. Please be advised that we do ***not*** participate with ***Medicaid*****.**

CANCELLATION
All cancellations must be done within a 24 hours period in order to avoid a penalty fee.

We look forward to your visit.

A Division of

Patient Registration Form

Please Complete All Information

Appointment Date: _______________

Patient Information

Last Name: ___________________________ First Name: ___________________________ M.I.: __________

Date of Birth____/_____/____ Age: _______ SSN: _____-____-_____ Sex: M / F Marital Status: S M D W

Race: ________________________ Ethnicity: ______________________ Pref. Language_____________________

Address: _______________________________________ City: ______________ State: _______ Zip Code: ________

Email: __________________________________ Home Phone: _________________ Cell Phone: ________________

Employer: ___________________ Emp. Address: _________________________ Emp. 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 ___________________________________

Insurance Address: ____

Subscriber's Name: _______________________________________ Relationship to Patient: ___________________

Address if different from patient: __________________ City: ______________ State: _______ Zip Code: ___________

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 ___________________________________

Insurance Address: ____

Subscriber's Name: _______________________________________ Relationship to Patient: ___________________

Patient/Guardian Signature: ____ Date: ______________________

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.

Advanced Gastroenterology Associates
Atlantic Coast Gastroenterology Associates
Gastroenterologists of Ocean County
Middlesex Monmouth Gastroenterology
Monmouth Gastroenterology
Red Bank Gastroenterology Associates
Shore Gastroenterology Associates

**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.

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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 Phon*e # _________________

- € 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

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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 will provide all current (we require both sides of your insurance card) at the time of service as well as a current photo ID.
6. I understand that I will be charged $35 for any check returned by my bank for any reason.

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

____	____________________________
Signature of Patient or Guardian	Today's Date

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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 authorizes 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