



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

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BOARD CERTIFIED IN GASTROENTEROLOGY & HEPATOLOGY

JOSEPH F. BINNS, MD

Patient Name:			MRN #:	
Appointment Date:/_ Day of the Week	Month	/ / _ Day	Year	
Time of Appointment:		Arrival Time	e: nt time	
Dear Valued Patient, In order for us to process your visit in a ti paperwork prior to your arrival on the da			ry that you <i>comp</i>	olete your
Please bring the following:				
☐ Completed Paperwork				
☐ Your Insurance Card				
☐ Your Rx Card				
☐ Your Driver's License for verification	n purposes			
\square Your Co-Pay, if applicable, is due at	the time of s	ervice		
☐ Referral if needed				
\square Blood Work / Hospital Stays / CT So information that will assist in our phys			•	pertinent
Without these documents, we may not	t be able to pr	rovide you ı	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 <u>not</u> participate with <u>Medicaid</u>.

CANCELLATION

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

We look forward to your visit.



Appointment	Date:
ADDONLICHE	Date.

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г	au	CIIL		Hation

Last Name:	First Name:	M.I.:
Date of Birth:/ Age: S	SN: Sex: Marital	Status:
Race: Ethnicity:	Pref. Language:	
Address:		
Email:	Home Phone: C	Cell Phone:
Occupation:	Employer:	
Employer Address:	Em	nployer Phone:
Primary Care Physician:	Referring Physician:	
Pharmacy Name: Phar		
Pharmacy Phone: Rx C		
Emergency Contact:	Relationshin to Patient	
Emergency Contact Primary Phone:	·	
Insurance Carrier: Insurance Effective Date: / / Insurance Effective Date: / / Insurance Effective Date: / / / Insurance Effective Date: / / / Insurance Effective Date: / / / / Insurance Effective Date: / _ / / _ / / _ / / _ / / / _ / / _ / _ / _ / _ / _ / _ / _ / / _ /	rance Co Phone: Relationship to Patient:	
Subscriber's Date of Birth:/ SS		
Secondary Insurance Please provide a corumnic Carrier: Insurance Effective Date:/ Insurance Effective Date:/	Policy ID#:	Group #:
Subscriber's Name:		
How did you hear about our practice?		
Signature of Patient or	 Guardian	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 <u>any purpose</u>. 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.



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

Print Patient's Name	Date
I,(Signature of Patient or Parent or Legal Guardian)	_, acknowledge that
Have either received a copy of this office's NOTICE OF PRIVACY PRAC	CTICES or that
Allied Digestive Health's NOTICE OF PRIVACY PRACTICES was made	available to me
to receive.	
I,, consent to the use (Signature of Patient or Parent or Legal Guardian)	and disclosure of
My personal health information by your office for Treatment, Billing / Pay	ment and Health care
Operations as outlined in the NOTICE OF PRIVACY PRACTICES.	



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.

	consent to be contacted in the following manne	ſ :
Primar	y Telephone #	
€	Do not call this number	
€	Ok to leave message to call back only	
€	Ok to leave message with results and detail	ed information, including billing.
Secon	dary Phone #	
€	Do not call this number	
€	Ok to leave message to call back only	
€	Ok to leave message with results and detail	ed information, including billing.
	persons authorized to receive my health inform Relationship: Relationship: Relationship:	
	ation of Consent	
You ma	ay revoke this consent in the use and disclosur	e of you Protected Health Information at any time. sclosure that has already occurred prior to the date of be affected.
	reviewed this consent form and hereby give my e my Protected Health Information in accordan	permission to Allied Digestive Health to use and ce with these guidelines.
Signati	ure of Patient or Patient Representative	Date
Printed	I Name of Patient or Patients Representative	



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



Assignment of Benefits

I hereby authorize any insurance carrier, including Medic Health for any services rendered to me or my covered do me toward the reimbursement of any medical expenses financially responsible for payment of all services re insurance or not. A photocopy of this authorization sha original.	ependents of any amounts otherwise payable to incurred at this facility. I understand that I am gardless of any payment issued by my
Signature of Patient or Guardian	Today's Date
Release of Medical Reco	rds and Information
I hereby authorizes the release of any Protected Healthd company, or their authorized third parties involved in my otherwise.	• ,
Signature of Patient or Guardian	Todav's Date





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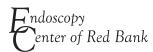
Patient Interview Form

PATIENT INFORM	MATION					
First Name			Last Name			
MRN			Date of Birth			
Age			Notes			
EMAIL <i>Please check one</i> □ Personal	• •		ions 			
CONTACT PREFERENCE ☐ Cell number only ☐ A		Patient Portal HIPPA co	ompliant email □Pa	atient declines to	specify	er
RACE Select one or more ☐White ☐Black or Africa	can American [⊒Asian □American	Indian or Alaska Nat	ive □Native ⊢	lawaiian or Othe	r Pacific Islander
☐Unknown ☐Patient d	eclines to specify	/				
ETHNICITY Hispanic or Latino	Not Hispanic or L	_atino □Patient decli	nes to specify			
SEX ☐ Male ☐ Female ☐ C	Other					
PREFERRED LANGUAG □ English □ Spanish/Ca		nt declines to specify				
ALLERGIES						
☐Patient has no known a	llergies	☐Patient has no kn	own drug allergies			
☐Asprin <i>Tartrazine only</i>	Penicillins	☐Codeine Sulfate	☐Bactrim/Sulfa	■Milk	■NSAID's	□Kiwi
□Eggs	Peanuts	□Latex	☐Band-Aids	Morphine	□ lodine Injed	table Dye
Other:						
CONSENT TO IMP	_					
I consent to obtaining a his ☐Yes ☐No	story of my medic	cations purchased at pr	narmacies.			

PHARMACY Name						
NameAddress					one	
CURRENT MED	ICA	TIONS				
□None						
Name			Name		Name	
dose						
Name			Name		Name	
dose						
IMMUNIZATIO	NS					
□None						
☐Hep A	ПН	ер В	□HPV	☐Flu Vaccine	□MMR	
when	when		when	when	when	
□Pneumovax	□те	etanus	□Varicella	Other		
	when		when	when		
DIAGNOSTIC S	STU	DIES / T	ESTS			
□None						
Abdominal Ultrasouwhen	und	Colonos		☐CT Abdomen/Pelvis when	□EGD when	□ERCP when
□EUS		□Flexible	Sigmoidoscopy	□Mammogram	☐MRI Abdomen/Pelvis	☐Small Bowel Imaging
when		when		when	when	when
Other						
when						
PREVIOUS PRO	OCE	DURES				
□None						
Appendectomy when		C-Section		Cardiac Stent	☐Colon Resection when	☐ Defibrillator when
Gall Bladder Remo	val	☐Hystered	•	Lung Surgery	☐Obesity Surgery	□Pacemaker
Other						

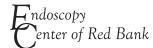


when_



PAST OR PRESENT	F MEDICAL CONDIT	IONS		
Acid Reflux	☐Arrhythmia when	Arthritis	☐Asthma when	Celiac Disease
Cirrhosis when	Colon Cancer	Colon Polyps	☐Congestive Heart Failure	C.O.P.D.
Coronary Artery Disease when	Crohn's Disease	Depression when	when Diverticulitis when	☐Diabetes Mellitus insulin dependent when
□ Diabetes Mellitus non-insulin dependent	Elevated Cholesterol	Gout	☐Heart Attack when	☐Hepatitis B
when	☐HIV when	☐Hypertension when	☐Hyperthyroidism when	☐ Hypothyroidism when
when	☐Kidney Disease when	Liver Disease when	☐MRSA when	☐Osteopenia
Syndrome when	Seizures when	☐Sleep Apnea when	☐Stroke (CVA) when	☐Transient Ischemic Attack
Osteoporosis when	☐Valvular Heart Disease when	☐Ulcerative Colitis when		when
Otherwhen		_		
SOCIAL HISTORY Occupation			_Number of Children	
MARITAL STATUS ☐Single	☐ Married	□Divorced	☐Separated	□Widowed
☐Civil Union	Unknown	□Other		
ALCOHOL None Quantity	Number Frequer	CAFFEINE ☐None		
□Beer		— □Coffee	☐Soft Drink ☐Tea	Chocolate
☐ Hard Liquor		<u></u>		
□Wine ———				

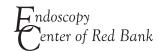




TOBACCO								
☐ Current every day smoker☐ Smoker, current status unknown		☐ Current some day smoker☐ Light tobacco smoker			☐ Former smoker ☐ Heavy tobacco smoker		□ Never smoker	
							□Unkno	☐Unknown if ever smoked
DRUG USE □None	Quar	ntity	Number		Frequency			
Recreational Drug Use:		uty Number			rrequericy			
EXERCISE None	Quar	ntity	Number	_	Frequency			
□ Type				_				
FAMILY MEDICAL H ☐ No knowledge of family hi No family history of			□Polyps					
HEALTH STATUS		Mother		Father		Sister		Brother
Alive								
Deceased/Age								
Cause of Death	-							
DIAGNOSES								
Barrett's Esophagus								
Breast Cancer								
Colon Polyps								
Colorectal Cancer								
Esophageal Cancer								
Gynecologic Cancer								
Liver Cancer								
Liver Disease								
Lung Cancer								
Pancreatic Cancer								
Prostate Cancer								
Stomach Cancer								
Ulcerative Colitis/								



Crohn's Disease



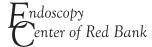
REVIEW OF SYSTEMS (Symptoms you are experiencing today)

Allergic/Immunologic		
☐ None	Υ	N
HIV exposure		
Persistent infections		
Strong allergic reactions or uticaria	Ц	
Cardiovascular	V	NI NI
None	Υ	<u>N</u>
Chest pain Very short of breath w/ normal exercise	H	H
Irregular heart beat	H	
Orthopnea		
Palpitations	П	
Peripheral edema	ī	
Syncope	$\overline{\Box}$	
Constitutional	_	
□ None	Υ	N
Fatigue		
Fever		
Loss of appetite		
Malaise		
Sweats		
Weight gain		
Weight loss		
ENMT	v	
	v	N
None	<u>Y</u>	<u>N</u>
Difficulty swallowing	<u> </u>	
Difficulty swallowing Dizziness		
Difficulty swallowing Dizziness Ear pain		
Difficulty swallowing Dizziness Ear pain Nasal obstruction		
Difficulty swallowing Dizziness Ear pain Nasal obstruction Nose bleed		
Difficulty swallowing Dizziness Ear pain Nasal obstruction Nose bleed Sore throat		
Difficulty swallowing Dizziness Ear pain Nasal obstruction Nose bleed Sore throat Hearing loss		
Difficulty swallowing Dizziness Ear pain Nasal obstruction Nose bleed Sore throat Hearing loss Endocrine		
Difficulty swallowing Dizziness Ear pain Nasal obstruction Nose bleed Sore throat Hearing loss Endocrine □ None		
Difficulty swallowing Dizziness Ear pain Nasal obstruction Nose bleed Sore throat Hearing loss Endocrine	 	
Difficulty swallowing Dizziness Ear pain Nasal obstruction Nose bleed Sore throat Hearing loss Endocrine □ None Excessive thirst	 	
Difficulty swallowing Dizziness Ear pain Nasal obstruction Nose bleed Sore throat Hearing loss Endocrine None Excessive thirst Hair loss Heat intolerance Eyes	Y	
Difficulty swallowing Dizziness Ear pain Nasal obstruction Nose bleed Sore throat Hearing loss Endocrine □ None Excessive thirst Hair loss Heat intolerance Eyes □ None	Y	
Difficulty swallowing Dizziness Ear pain Nasal obstruction Nose bleed Sore throat Hearing loss Endocrine None Excessive thirst Hair loss Heat intolerance Eyes None Double vision	Y	
Difficulty swallowing Dizziness Ear pain Nasal obstruction Nose bleed Sore throat Hearing loss Endocrine □ None Excessive thirst Hair loss Heat intolerance Eyes □ None	Y	

Gastrointestinal	
☐ None	ΥN
Difficulty swallowing	
Heartburn	
Abdominal pain	
Abdominal swelling	
Change in bowel habits	
Constipation	
Diarrhea	
Gas	
Jaundice	
Nausea	
Rectal bleeding	
Stomach cramps	
Vomiting	
Genitourinary	V N
☐ None Dark urine	YN
Dark urine Decrease in urine flow	
Dysuria	
Frequent urinary infections	
Frequent urination	
Hematuria	
Impotence	
Nocturia	
Urethral discharge/incontinence	
Urethral discharge/incontinence Hematological/Lymphatic	
Urethral discharge/incontinence Hematological/Lymphatic □ None	
Hematological/Lymphatic ☐ None	
Hematological/Lymphatic	
Hematological/Lymphatic ☐ None Bleeding gums/palpable	
Hematological/Lymphatic ☐ None Bleeding gums/palpable lymph nodes	
Hematological/Lymphatic None Bleeding gums/palpable lymph nodes Easy bruising Prolonged bleeding Integumentary	Y N
Hematological/Lymphatic ☐ None Bleeding gums/palpable lymph nodes Easy bruising Prolonged bleeding Integumentary ☐ None	Y N
Hematological/Lymphatic None Bleeding gums/palpable lymph nodes Easy bruising Prolonged bleeding Integumentary None Allergies	Y N
Hematological/Lymphatic None Bleeding gums/palpable lymph nodes Easy bruising Prolonged bleeding Integumentary None Allergies Dryness	Y N
Hematological/Lymphatic ☐ None Bleeding gums/palpable lymph nodes Easy bruising Prolonged bleeding Integumentary ☐ None Allergies Dryness Hives	Y N
Hematological/Lymphatic ☐ None Bleeding gums/palpable lymph nodes Easy bruising Prolonged bleeding Integumentary ☐ None Allergies Dryness Hives Itching	Y N
Hematological/Lymphatic None Bleeding gums/palpable lymph nodes Easy bruising Prolonged bleeding Integumentary None Allergies Dryness Hives Itching Jaundice	Y N
Hematological/Lymphatic ☐ None Bleeding gums/palpable lymph nodes Easy bruising Prolonged bleeding Integumentary ☐ None Allergies Dryness Hives Itching Jaundice Lesions	Y N
Hematological/Lymphatic None Bleeding gums/palpable lymph nodes Easy bruising Prolonged bleeding Integumentary None Allergies Dryness Hives Itching Jaundice Lesions Rashes	Y N
Hematological/Lymphatic None Bleeding gums/palpable lymph nodes Easy bruising Prolonged bleeding Integumentary None Allergies Dryness Hives Itching Jaundice Lesions Rashes Musculoskeletal	Y N
Hematological/Lymphatic □ None Bleeding gums/palpable lymph nodes Easy bruising Prolonged bleeding Integumentary □ None Allergies Dryness Hives Itching Jaundice Lesions Rashes Musculoskeletal □ None	Y N
Hematological/Lymphatic □ None Bleeding gums/palpable lymph nodes Easy bruising Prolonged bleeding Integumentary □ None Allergies Dryness Hives Itching Jaundice Lesions Rashes Musculoskeletal □ None Arthritis	Y N
Hematological/Lymphatic □ None Bleeding gums/palpable lymph nodes Easy bruising Prolonged bleeding Integumentary □ None Allergies Dryness Hives Itching Jaundice Lesions Rashes Musculoskeletal □ None Arthritis Back pain	Y N
Hematological/Lymphatic □ None Bleeding gums/palpable lymph nodes Easy bruising Prolonged bleeding Integumentary □ None Allergies Dryness Hives Itching Jaundice Lesions Rashes Musculoskeletal □ None Arthritis Back pain Gout	Y N
Hematological/Lymphatic □ None Bleeding gums/palpable lymph nodes Easy bruising Prolonged bleeding Integumentary □ None Allergies Dryness Hives Itching Jaundice Lesions Rashes Musculoskeletal □ None Arthritis Back pain Gout Joint deformity	Y N
Hematological/Lymphatic □ None Bleeding gums/palpable lymph nodes Easy bruising Prolonged bleeding Integumentary □ None Allergies Dryness Hives Itching Jaundice Lesions Rashes Musculoskeletal □ None Arthritis Back pain Gout	Y N

Neurological		
□ None	Y	N
Dizziness		
Fainting		
Frequent headaches		
Migraine		
Numbness or tingling		
Seizures		
Tremors		
Vertigo		
Memory loss		
Psychiatric		
☐ None	<u>Y</u>	N
Anxiety		
Depression		
Difficulty sleeping		
Hallucinations		
Nervousness		
Panic attacks		
Paranoia		
Respiratory	.,	
None	<u>Y</u>	<u>N</u>
Asthma		
Cough		닏
Dyspnea		
Excessive sputum		
Coughing up blood		
Shortness of breath w/	Ц	Ц
exercise	_	_
Wheezing	Ц	Ц





	•		ormation shared with other health care entities.	
	•	RENCE care and follow up o	care reminders.	
REVIEWE	D WITH ☐Parent	□Guardian	□Not Present	
SIGNATUI	RE			
Signature			Date	



