Mid State Gastroenterology, LLC
901 West Main Street
Medical Arts Bldg., Suite 107
Freehold, NJ 07728
Phone: 732-303-3888 Fax: 732-414-2292

Please Complete the Entire Form:

Last Name: _____

First Name: _____ Middle Name _____

Address: _____

City: _____ State: _____ Zip: _____ **Home #**

_____ **Cell**: _____

Contact Preference:

Home Phone: ☐Yes ☐ No Cell phone: ☐ Yes ☐ No Work phone: ☐ Yes ☐ No Consent to Call: ☐ Yes ☐ No

Social Security #: _____

Birth date: _____ Age: _____ Sex: ☐ M ☐ F

Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Partner

Email Address: _____

(by declining email information for patient portal, you are also declining patient summary)

Occupation: _____ Work: _____

Employer Name/Address: _____

Emergency Contact:_____ Relationship:_____

Address: _____ Phone#: _____

Primary Care Physician: _____ Phone # _____

Office Location: _____

Primary Insurance Information: Co-Pay Amount $_____

Insurance Carrier: _____

ID: _____ Group #: _____

Subscriber's (Policy Holder) Name: _____ Relation to Patient: _____

SS#: _____ Subscriber's Date of Birth:_____

Secondary Insurance Information: If Applicable Co-Pay Amount $_____

Insurance Carrier: _____

ID _____ Group#: _____
Subscriber's (Policy Holder) Name: _____ Relation to Patient: _____
SS#: _____Subscriber's Date of Birth: _____

Please Answer all three (3) questions Ethnicity: Check One

☐ **Hispanic/Latino** ☐**Non Hispanic/Non Latino** ☐ **Decline to Report/Unreported**

Primary Language: _____ Decline to report _____

Race: Check One

☐ American Indian ☐ African American ☐ Alaskan Native

☐ Asian ☐ White ☐ Native Hawaiian/Pacific Islander ☐ Decline to report/Unreported

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Consent to:

Review Medication history: ☐ **Yes** ☐ **No**

Receive Reminder Phone Calls: ☐ **Yes** ☐ **No**

Content to text ☐ **Yes** ☐ **No**

Share Medical and demographic information with your other health care providers: ☐ **Yes** ☐ **No**

NO SHOW FEES:

I am aware a NO SHOW fee will be charged to my account if I fail to cancel any appointment prior to 24 hours. I understand that the NO SHOW fees are **$250** for initial office visit, **$50** for follow-up office visit and **$250** for a procedure.

Failure to sign this acknowledgment will not prevent this policy from becoming effective

****Patient signature**_____****

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began in 2003. Many of the policies have been our practice for years. This form is the "friendly" version. A more complete text is posted in our office.

Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. It is the policy of this office to remind patients of their appointment. We may do this by telephone, email, US mail or by any means convenient for the practice and/or requested by you. We may send you other communications informing you of changes to our office policy and new technology that you might find valuable or informative. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA. You understand and agree to inspections of

the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services. We agree to provide patients with access to their records in accordance with state and federal laws. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request. A full copy of the HIPAA policy is available upon request.

For Medicare Assignment of Benefits, I request that payment of authorized Medicare benefits be made either to me or on my behalf to Mid State Gastroenterology, LLC for any services furnished me by Mid State Gastroenterology, LLC. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

For all other Insurance Assignment of Benefits, I hereby authorize and instruct any and all insurance companies involved with my healthcare coverage to make payment directly to Mid State Gastroenterology, LLC. This is for the Professional Medical Expense benefits allowable and otherwise payable to me under my current insurance policy as payment towards the total charges for professional services rendered. This payment shall not exceed my indebtedness to the above practice, and I have agreed to pay any balance if said professional service charges are over and above this insurance portion of payment. A photocopy of this Assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to my Insurance Company or adjuster involved in the case, unless I have made alternative arrangements with respect to this data.

I understand that I am financially responsible for all charges whether or not paid by said insurances including copays, deductibles, coinsurance and non-covered charges. I authorize and give consent for my provider to bill me directly for recommended services performed that are not covered under the terms of my health plan. I authorize the physician to release any medical information required to process this claim. I authorize my provider's office to contact me by telephone to remind me of my appointments.

Statements are mailed out monthly by first class mail. We trust that all mailed statements are received by our patients. Therefore, if payment in full is not received on your account within 30 days, then the past due account may be reviewed for possible transfer to a collection agency. I also understand that any unpaid balances transferred to a collection agency or attorney are subject to an additional administration charge of Seventy-five Dollars ($75) or 25% of the balance owed, whichever is greater, and are my responsibility. These fee may change at any time without prior notice.

I have received the notice of Assignment of Benefits, Privacy Practices and Financial Policies statements and I have been provided the opportunity to review them. I hearby consent and acknowledge my agreement to the terms set forth in the HIPAA information form and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

***Patient's Signature**: _____ Date: _____

Print Patient Name: _____