South Jersey Gastroenterology, P.A.

Date: _____

Personal Information:

Acct: _____

Name: _____ DOB _____

Address: _____ SSN: _____

City/State/Zip: _____ Home Phone: _____

Occupation: _____ Work Phone: _____

E-Mail Address: _____ Cell Phone: _____

Emergency Contact: _____ Phone: _____

Marital Status: ☐ Single ☐ Divorced ☐ Domestic Partner

☐ Married ☐ Widowed

Race: _____ Language: _____ Ethnicity: _____

Physician Information:

Primary/Referring Doctor: _____ Phone: _____

Address/City/State/Zip: _____

Primary Insurance Information:

Insurance Company: _____

Relationship to Policy Holder: _____ ID #: _____

Policy Holder Information:

Name: _____ DOB: _____

Employer: _____ SSN: _____

Secondary Insurance Information:

Insurance Company: _____

Relationship to Policy Holder: _____ ID #: _____

Policy Holder Information:

Name: _____ DOB: _____

Employer: _____ SSN: _____

IMPORTANT NOTE:

This information is required by the Government in order for your claim to be electronically submitted to your carrier for payment. Failure to provide this information will result in you being responsible for your bill. If a SSN is not provided for both the Patient and Subscriber, and the claim is rejected, the patient is responsible for the balance of the bill.

Thank you for your cooperation.

South Jersey Gastroenterology, P.A.

Date: _____

Personal Information:

Name on Card: _____

Issuer #: _____

ID: _____

RX Group: _____

RX Bin: _____

RC PCN: _____

Mail-Away Pharmacy Information:

Pharmacy Name: _____

Address: _____

City/State/Zip: _____

Phone: _____

Fax:: _____

Preferred Retail Pharmacy Information:

Pharmacy Name: _____

Address: _____

City/State/Zip: _____

Phone: _____

Fax:: _____

Preferred Retail Pharmacy Information:

Pharmacy Name: _____

Address: _____

City/State/Zip: _____

Phone: _____

Fax:: _____

Patient Name: _____

Please state the reason for this visit: (if this visit because of illness or pain, please fill out page 5)

Are you allergic to any medications, that you are aware of? _____**NO** _____**YES** (please list)

Are you allergic to any dyes iodine, shellfish, latex, eggs or soybeans? _____**NO** _____**YES** (please list)

Please list all medications and dosages that you are currently taking (including over the counter medications):

Are you currently taking Aspirin? YES NO **Advil or Ibuprofen-like products?** YES NO

Personal History

Have you ever been told that you have any of the following conditions? (**circle** yes or no)

a. Ulcers .....YES NO
b. Gallbladder Disease..... YES NO
c: Pancreas Problems.....YES NO
d. Liver Problems ..... YES NO
e. Stomach Problems.....YES NO
f: Intestinal Problems..... YES NO
g. Heart Disease .....YES NO
h. Lung Problems..... YES NO
i. High Blood Pressure .....YES NO
j. Diabetes ..... YES NO
k. Stroke.....YES NO
l. Cancer..... YES NO
m. Thyroid Problems.....YES NO
n. Kidney Problems..... YES NO
o. Colon Polyps .....YES NO

If you answered YES to any of the above, please explain below, indicating each item by letter:

Note any known conditions, other than those listed above:

Patient Name: _____

Have you had surgery? _____NO _____YES (please list, include type, hospital and year)

Type of Surgery	*Hospital*	*Year of Surgery*

Do you require antibiotics before dental or surgical procedures? _____NO _____YES (please explain below)

_____

_____

_____

Family History

Have any of your family members (parents, grandparents, aunts, uncles, siblings, children) been told that they now have or have had any gastrointestinal problems or any of the previous conditions, including colon polyps, colon cancer, ulcers, liver disease, celiac or other abdominal problems?

Father _____

Mother _____

Brother _____

Sister _____

Child _____

Grandparents _____

Aunts/Uncles _____

Please **circle** either YES or NO

Do you use alcohol?..... YES NO.....How much? _____

Have you used alcohol in the past?..... YES NO.....For how long and when did you stop?_____

Do you smoke? ..... YES NO.....How much? _____

Have you smoked in the past?..... YES NO.....For how long and when did you stop?_____

Do you drink coffee? ..... YES NO.....How much? _____

Have you used intravenous drugs? ..... YES NO

For Women Only:

Could you be pregnant?..... YES NO

Please check if you have ever had any of the following specific problems:

- ❑ Gastrointestinal Bleeding
- ❑ Mouth Ulcers
- ❑ Sleep Apnea
- ❑ Difficulty with Anesthesia
- ❑ Anxiety
- ❑ Depression
- ❑ Attempted Suicide
- ❑ Kidney Stones
- ❑ TB
- ❑ Anemia
- ❑ Constipation
- ❑ Change in Bowel Habits
- ❑ Blood Transfusion
- ❑ Hepatitis
- ❑ Jaundice
- ❑ Poor Blood Clotting
- ❑ Easy Bruisibility

Please check any of the following specific problems that you have had, within the <u>last 6 months</u>:

- ❑ Trouble Swallowing
- ❑ Heartburn
- ❑ Filling up easily with meals
- ❑ Nausea
- ❑ Vomiting
- ❑ Abdominal Pain
- ❑ Rectal Bleeding
- ❑ Black Stools
- ❑ Bloody Stools
- ❑ Constipation
- ❑ Use Laxatives
- ❑ Diarrhea
- ❑ Change in Bowel Habits
- ❑ Double Vision
- ❑ Dry Eyes
- ❑ Earaches
- ❑ Hoarseness
- ❑ Dry Mouth
- ❑ Chest Pain
- ❑ Wheezing
- ❑ Shortness of Breath
- ❑ Trouble Urinating
- ❑ Other Urinating problems
- ❑ Burning while Urinating
- ❑ Blood in Urine

❑ Weight Loss, how much _____ over what period of time: _____

- ❑ Fever
- ❑ Chills
- ❑ Night Sweats
- ❑ Fatigue
- ❑ Swollen Glands
- ❑ Swollen Joints
- ❑ Hands turn white, blue or red
- ❑ Frequent Colds
- ❑ Painful Red Eyes
- ❑ Back Pain
- ❑ Joint Pain
- ❑ Muscle Pain
- ❑ Arm Weakness
- ❑ Leg Weakness
- ❑ Altered sensation in arms, legs or face
- ❑ Fainting
- ❑ Itching
- ❑ Rash

Patient Name: _____

When did your *gastrointestinal* pain or illness first begin, please be specific:

How often does your pain or illness occur:

How long does your pain or illness last:

How severe is it, based on a scale of 0 – 10, please circle your answer:
0 being no pain at all, 10 being the most severe pain you've ever felt:

1 2 3 4 5 6 7 8 9 10

What, if anything, relieves your pain or illness:

What, if anything, makes your pain or illness worse or starts it up:

If you are having pain, where is it located and does it travel anywhere:

Reviewed By: **Date:**

Cancellation Notice

When you make an appointment with us, we reserve a block of time especially for you and only you. If you do not appear for your appointment, that block of time is unavailable to someone else who is waiting for our care, without sufficient notice. We require two (2) business days notice to cancel or reschedule an office visit and three (3) business days to cancel a procedure.

If you fail to give the required notice, you will be subject to a $50.00 cancellation fee for an office visit and a $100.00 fee for a procedure. The cancellation charges are not covered by your insurance. We appreciate your cooperation and consideration in adhering to this policy.

Notice to Patients Regarding Referrals

It is the Patients Responsibility to get referrals from your family physician. Some insurance companies require patients to have referrals before they have a consultation, procedure, follow-up visit after procedures or office visits. Your insurance company made this policy, we are simply asking you to make sure you have your referrals prior to any healthcare services being rendered.

Also, please note the expiration date of your referral. If your referral has expired, it will be your responsibility to obtain a new referral and not the responsibility of this office. Unfortunately, insurance companies will not let the family doctors backdate a referral. Therefore, if you would still prefer to be seen without a referral, the option will be for you to pay for the entire visit at the time of service.

We regret any inconvenience that this referral policy may cause you. However, we are required by law to abide by the regulations your insurance company has mandated. Thank you for your cooperation with this insurance issue.

Payment Authorization

I authorize direct payment of all medical benefits to which I am entitled, including Medicare, major medical, private insurance, or any other health plan to South Jersey Gastroenterology, P.A.

I also permit a copy of this authorization to be used in place of the original. This assignment will remain in effect until revoked by me, in writing. I understand that as these services were performed for me or my legal dependent, I am financially responsible for all charges whether or not paid by insurance.

HIPAA Privacy Practices

I have either received the Notice of Privacy Practices or have previously had the opportunity to review it.

Your signature below indicates you have read each of the above (Cancellation Notice, Referral Notification, Payment Authorization and HIPAA Privacy Practices).

Patient Signature: _____

Date: _____

Name: _____

Advance **B**eneficiary **N**otice (ABN)

NOTE: You need to make a choice about receiving these laboratory tests.

Your insurance may not pay for the laboratory test(s) that are described below. Insurance does not pay for all of your health care costs; it only pays for covered items and services when insurance rules are met. The fact that Insurance may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason you physician recommended it. Insurance may not pay for the laboratory test(s) depending upon your condition.

Depending upon your condition, Insurance may not pay for the following tests:		
☐ CBC	☐ Lipid Panel	☐ T-4 Free
☐ CEA	☐ Occult Blood, Mcr Scr or Dx	☐ Culture, Urine Routine (include ID & Susceptibilities when pos)
☐ Cholestrol, Total	☐ Pap Smear	☐ _____
☐ Digoxin	☐ PSA, Mcr Scr or Dx	☐ _____
☐ Ferritin	☐ PT w/INR	☐ _____
☐ Glucose, Serum or Plasma	☐ PTT, Activated	☐ _____
☐ HDL Cholestrol	☐ TSH	☐ _____
☐ Hemoglobin A1C	☐ TSH w/Reflex T-4 Free	☐ _____
☐ Iron, Total	☐ T-3 Update	☐ _____
☐ Iron (Tot), IBC % Sat	☐ T-4 Thyroxine	☐ _____

The purpose of this form is to help you make an informed choice about whether or not you want to receive these laboratory tests, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should read this entire notice carefully.

PLEASE CHOOSE ONE OPTION. CHECK ONE BOX. SIGN AND DATE THE FORM:

☐ **OPTION 1: YES. I WANT TO RECEIVE THESE LABORATORY TESTS**

I understand that I may be billed for laboratory tests and that I may have to pay the bill while Insurance is making its decision.

If my Insurance denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, out of pocket. I do understand that I may be able to appeal any Insurance decision.

☐ **OPTION 2: NO. I HAVE DECIDED NOT TO RECEIVE THESE LABORATORY TESTS**

I have decided I will not receive these laboratory tests. I agree not hold South Jersey Gastroenterology liable for the outcome of any tests I voluntarily decide not to receive.

_____ _____

Date Signature of patient or patient representative

South Jersey Gastroenterology, P.A.

Board Certified in Gastroenterology

Permission to Release Information to Non-Medical Persons or Emergency Contacts

Please list any family members (including spouse), friends or home health care personnel you authorize to receive information on your medical condition (e.g. test results, hospital status appointment information etc.) or billing information.

I, _____ give South Jersey Gastroenterology permission to release medical and/or billing information to the following people:

Name	Relationship	Phone

_____ _____

Patient Signature Date

South Jersey Gastroenterology, P.A.

Board Certified in Gastroenterology

Patient information regarding Colonoscopy, EGD, and follow up care

A Colonoscopy is recommended to examine the colon in an attempt to detect polyps and/or potentially cancerous tumors at an early stage. Most patients for whom this test is recommended do not have a serious illness, but the possibility nevertheless exists. Early detection offers the best chance for cure; conversely, delay in diagnosis can result in an incurable condition. This is because cancer which was initially confined to a small area can spread throughout the body if not detected early.

An Upper Intestinal Endoscopy (EGD) evaluates the upper intestinal tract. Specifically, it allows your doctor to visualize the esophagus, stomach and the beginning of the intestinal tract, allowing illnesses such as inflammation or early tumors to be detected. Early detection offers the best chance for cure of these conditions. Although there may be a very simple, benign reason for your current symptoms, the potential for more serious problems (including cancer) always exists.

Follow-up office visits are important in facilitating the early diagnosis and treatment of your condition. It is important that you do not cancel or postpone your office visit. Gastrointestinal and liver problems are likely to have better outcomes when diagnosed early. Any delay in diagnosing or treating most gastrointestinal and liver problems can lead to serious consequences, potentially converting a treatable and curable condition into an incurable one. It is therefore imperative that you receive your planned tests (such as blood work, CT scans, ultrasounds, Colonoscopy, Upper Endoscopy (EGD), and GI x-rays), and that you keep your office visits as recommended by the physicians at South Jersey Gastroenterology. This includes post-procedure office visits (normally, following Colonoscopy and EGD).

I understand the risks of not having this procedure(s) performed in a timely fashion and/or cancelling or rescheduling my office visit. I have read the contents of this statement and understand the risks that have been explained herein. I have been advised that my physician is available to answer any questions I may have. I acknowledge that if I miss or cancel an appointment, it is my responsibility to reschedule. I have received a copy of this statement.

Patient Name (please print): _____

Patient Signature: _____

Date: _____

South Jersey Gastroenterology, P.A.

Board Certified in Gastroenterology

Protecting Your Health Information

Our Commitment to Your Privacy

South Jersey Gastroenterology (SJGI) is dedicated to maintaining the privacy of your individually identifiable health information. We understand that medical information about you and your health is personal and we are committed to protecting medical information about you. We create a record of the care and services you receive at our office. We need this record to provide you with quality care and to comply with certain legal requirements. The terms of this notice apply to all records containing your personal health information that are created or retained by SJGI.

Identity Theft, Credit Card Fraud, Computer Viruses

Concern for the privacy and security of personal information, has never been greater. Our concern for the safety and security of your personal healthcare information has never been taken more seriously.

While we have always gone to great lengths to ensure the privacy of your personal health information, we will be getting additional help from the Federal Government in the form of new regulations. These regulations will help standardize privacy and security requirements across the country and across all different types of healthcare organizations.

New Regulations Passed

The regulations are part of the Health Insurance Portability and Accountability Act or HIPAA, for short. HIPAA does three primary things:

1. It helps standardize and simplify the way healthcare organizations exchange electronic health care data.
2. If provides consumers with additional protections for getting and maintaining health insurance coverage; although it does not guarantee coverage.
3. It creates new security rules to ensure the safety and privacy of individual health information and medical records.

HIPAA Ensures the Privacy and Security of Individual health Information

Currently, individual state laws govern use and disclosure of this information, creating many inconsistencies and gaps in the way your health information is protected. HIPAA sets minimum security and privacy standards for healthcare organizations to follow. If a state has more stringent privacy and security laws, then those would be followed instead. In addition, HIPAA sets heavy penalties for violations of these standards and the misuse of personal health information.

Defining Individual Health Information

Every time you go to see a doctor, are admitted to a hospital, fill a prescription or send a claim to an insurance company, a record Is made of your confidential health information. This type of information is referred to as individually identifiable health information and is the type of information regulated by HIPAA. It can be in any format—electronic, paper or oral.

Healthcare providers that collect and manage this type of information are therefore covered by these regulations including physicians, physical therapists, mental health professionals, dentists, chiropractors, optometrist, podiatrists and others. HIPAA also regulates the type of information in organizations such as: hospitals, health plans, employers, healthcare clearinghouses, claims processors, and others who conduct administrative and financial healthcare transactions.

Added Control Over Health Information

Under HIPAA, you have new rights to understand and control how your health information is used:

Right to Education—Healthcare providers and health plans are required to provide you with a clear written explanation of how they intend to you and disclose your information

Right to access medical records—You have the right to see and get copies of your medical records, request changes and receive a history of non-routine disclosures of your personal health information.

Right to consent—Healthcare providers are required to obtain prior consent before sharing personal health information for purposes other than treatment, payment and healthcare operations.

Right to Recourse—You have the right to file a formal complain if you believe that violations of the regulations were made.

In general, HIPAA tries to find a balance between protecting your privacy and allowing the appropriate flow of information between healthcare providers that is necessary for you to access care and receive quality healthcare services.

Complaints

If you think we may have violated your privacy rights, you can file a complaint with the Administrator at SJGI using one of the addresses below or with the Secretary of the US Department of Health and Human Services at:

US Department of Health and Human Services
200 Independence Avenue, Southwest
Washington, DC 20201

South Jersey Gastroenterology, P.A.

Board Certified in Gastroenterology

Patient Medical Release

PATIENT INFORMATION

Name: _____ Phone: _____

Address: _____ Date of Birth: _____

City/State/Zip: _____ SSN: _____

INFORMATION TO RELEASE

☐ Colonoscopy Report and Biopsy Date of Procedure: _____

☐ EGD Report and Biopsy Date of Procedure: _____

☐ Other: _____

_____

SEND MEDICAL RECORDS TO

Name: _____ Phone: _____

Company: _____

Address: _____

City/State/Zip: _____

RELEASE MEDICAL RECORDS FROM

Name: _____ Phone: _____

Company: _____

Address: _____

City/State/Zip: _____

PATIENT ACKNOWLEDGEMENT

I understand that, by signing this form, I am confirming my authorization for use and/or disclosure of protected health information described in this form with the people and/or organizations named in this form.

Signature: _____ Date: _____

If this form is signed by a personal representative for the patient*, please complete the following:

Representative's Name*: _____

Representative's Signature: _____

Relationship to Patient: _____

*Note: Must have a HIPPA form on file.