GANJ
GASTROENTEROLOGY ASSOCIATES OF NEW JERSEY

Date: _____

PATIENT REGISTRATION INFORMATION

PLEASE PRINT

☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr. (CHOOSE ONE) _____ Previous Name: _____
LAST NAME FIRST NAME MI (E.G., MAIDEN NAME)

Address: _____
STREET ADDRESS CITY STATE ZIP

Phone – Home _____ Cell: _____ Work: _____ ext _____

Ethnicity: _____ Race: _____

Primary Care Provider: _____ Referring Provider _____
NAME AND CITY (if different than PCP) (NAME AND CITY)

Patient date of birth: _____ ☐ M ☐ F ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Seperated SS #: ___-___-____

Patient employed by: _____

Business Address: _____
☐ Full time ☐ Part time ☐ Not employed ☐ Self employed ☐ Retired ☐ Active Military Duty ☐ Full time student ☐ Part time student

Responsible Party: _____ Phone: _____
(STATEMENTS WILL BE ADDRESSED TO RESPONSIBLE PARTY) LAST NAME FIRST NAME MI

Address of Responsible Party: _____ Relationship: _____
STREET ADDRESS CITY STATE ZIP

Emergency Contact: _____ Phone: _____
LAST NAME FIRST NAME MI

Address of Emerg. Contact: _____ Relationship: _____
STREET ADDRESS CITY STATE ZIP

Name of Primary Insurance _____ Subscriber ID # _____

Name of Insured: _____ Relationship: _____ Group #: _____

Policy Holder DOB: _____

Name of Secondary Insurance (if any) _____ Subscriber ID # _____

Name of Insured: _____ Relationship: _____ Group #: _____

Patient's e-mail address: _____

Your local pharmacy name: _____ City: _____ Phone _____

Mail Order pharmacy name: _____ City/State: _____ Phone _____

Preferred Language: _____ Translator Required? ☐ Y ☐ N

RELEASE OF PERSONAL INFORMATION TO THE PATIENT'S DESIGNEES

I authorize medical staff members of this practice to discuss my medical history, diagnosis, treatment and prognosis with those listed below.

Name	Phone Number	Relationship

Patient's home phone: ☐ OK to leave message with detailed information ☐ Do not leave details; leave message with callback number only

How did you learn of this practice? _____

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or my dependents and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I, _____ hereby authorize _____
(name of insured) (name of insurance company)
to pay and hereby assign directly to *Practice Name* all benefits, if any, otherwise payable to me for the services as described on the attached forms. I understand that I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to *Practice Name*, PA will be credited to my account, in accordance with the above said

_____ _____
(authorized signature of subscriber) (date)

GASTROENTEROLOGY DIAGNOSTICS
of Northern New Jersey, P.A.

205 Browertown Road • Suite 102 • Woodland Park, New Jersey 07424
(973) 890-4780 • Fax: (973) 890-1097

Rini Abraham, M.D., Pharm. D.
Oren E. Bernheim, M.D.
Ralph A. De Maio, M.D.
John J. Farkas, M.D.
Ashok Gupta, M.D.
Gary J. Kosc, M.D.
Michael M. Mainero, M.D.
Michael J. Martino, M.D.
George N. Pavlou, M.D.
Joseph G. Shami, M.D.
Ariy Volfson, M.D.

ACKNOWLEDGMENT OF PATIENT INFORMATION

In advance of the date of my scheduled procedure at GED, I have received the following information:

A. Disclosure of Financial Interest in Surgical Center
B. Patient Rights
C. Advance Directives

I give my permission for Gastroenterology Diagnostics to leave a telephone message at my:

Home Number: _____

Cell Number: _____

_____
Patient's Name (Please Print)

_____ Date _____
Patient's Signature

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DISCLOSURE OF FINANCIAL INTEREST IN SURGICAL CENTER

Public law/rule of the State of New Jersey/Board of Medical Examiners mandates that a physician, podiatrist and all other licenses of the Board of Medical Examiners inform patients of any significant financial interest held in a health care service. Accordingly, please take notice that practitioners in this office do have a financial interest in the following health care service to which patients are referred:

1. Gastro Diagnostics of Northern New Jersey, 205 Browertown Road, Woodland Park, NJ 07424

You may, of course, seek treatment at a health care service provider of your own choice. A listing of alternative health care service providers can be found in the classified section of your telephone directory under the appropriate heading.

Additionally, the Centers for Medicare & Medicaid Services Conditions of Coverage regarding ambulatory surgical centers mandate that ambulatory surgical centers disclose to patients and physician's financial interest in an ambulatory surgical center to which the physician refers his or her patients. Accordingly, please take notice the following are Physician Owners of Gastro Diagnostics of Northern New Jersey.

(i) Rini Abraham, M.D., Pharm. D.
(ii) Oren E. Bernheim, M.D.
(iii) Ariy Volfson, M.D.
(iv) John J. Farkas, M.D.
(v) Ashok Gupta, M.D.
(vi) Gary J. Kosc, M.D.
(vii) Michael M. Mainero, M.D.
(viii) Michael J. Martino, M.D.
(ix) George N. Pavlou, M.D.
(x) Joseph G. Shami, M.D.

Please sign below to acknowledge that you have been informed of the ownership interest in the above entities prior to or at the time you were referred to the above entity.

PATIENT'S NAME (Please Print) _____ DATE _____

PATIENT'S SIGNATURE _____

1130 McBride Avenue • 3rd Floor
Woodland Park, New Jersey 07424

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Gastroenterology Associates of New Jersey
Notice of Privacy Practices

Patient Name:_____ Date of Birth:_____

Date _____ /_____ /_____

The Notice of Privacy Practices describes how Protected Health Information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

GANJ is required by law to protect the privacy of health information that may reveal your identity, and to provide you with a copy of this notice, which describes the health information privacy practices of our practice, its medical staff, and affiliated health care providers that jointly perform payment activities and business operations with our Practice. "Protected Health Information" is information about you, including demographic information, that may identify you and genetic information, and that relates to your past, present or future physical or mental health or condition and related health care services.

I hereby acknowledge that I have received from Gastroenterology Associates of New Jersey, LLC ("GANJ") a copy of the Notice of Privacy Practices of GANJ. I understand that the Notice of Privacy Practices sets forth my rights relating to the use and disclosure of my personal health information and explains how GANJ can use and disclose my personal health information both with and without my authorization. I further understand that I may contact GANJ's Privacy Officer if I have any questions regarding the contents of this Notice or to file a complaint.

_____

Signature of Patient/Health Care Agent/Guardian/Relative
(This signature indicates having received a copy of the Notice of Privacy Practices.)

_ Patient is unable to sign due to medical reasons
_ Patient refuses to sign
_ Other (Please Explain)

This Acknowledgement Form will become part of your permanent medical record.

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Suite 201
Woodland Park, NJ 07424

PATIENT RESPONSIBILITY FOR FOLLOW-UP CARE PLEDGE

I,_____(print last name),_____(print first name), hereby acknowledge and understand that even with the best training, skill and experience, a medically trained professional is not always capable of solving my medical problems. Therefore, I understand it is important that any and all recommendations by doctors are followed completely in order to increase the likelihood of a positive and healthy treatment/outcome. I acknowledge and understand that if any physician in this office prescribes medicine to me that the proper taking of any such medicine shall be my sole responsibility (or my guardian who has attended this consultation). I agree to properly follow the prescribed dosage and frequency amounts of these medicines as recommended by my doctor.

I understand that if a doctor in this office refers me to see another doctor or receive another test including, but not limited to, a blood test, an MRI, or CT scan, this timely recommendation is important and essential the ultimate success of my treatment/outcome. I understand that it is not possible for any person in this office to constantly follow-up to ensure that I have followed these recommendations. Therefore, I understand that if I fail to see that specialist or obtain the test for which I was referred immediately, this can risk my current health or increase future health risks.

I understand that it is solely my responsibility to follow any of the medical advice given by any medical person in this office and any bad health outcome from my failure to follow the advice of my doctors should be expected.

Signature _____ Date _____

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OFFICE FINANCIAL POLICY

All Patients must complete our Patient Information Sheet before seeing the doctor.

REGARDING MANAGED CARE INSURANCE WE PARTICIPATE WITH:
You are responsible to supply our staff with your identification cards and all referrals And / or authorization forms PRIOR to seeing the doctor (if applicable). THERE WILL BE NO EXCEPTIONS.

If you do not have proper forms, I.D. cards or applicable co-pays as described in your insurance handbook, YOU MUST EITHER RESCHEDULE OR PAY FOR THE SERVICES IN FULL.

REGARDING NON-PARTICIPATING INSURANCE:
It is your responsibility to understand which insurance plans your doctor is participating with. The bill is your responsibility and is due at the time of service. Your insurance policy is a contract between you and your insurance company. Our office is not part of that contract.

REGARDING NON-PARTICIPATING INSURANCE'S "USUAL AND CUSTOMARY RATES":
Our practice is committed to providing the highest quality of treatment to our patients, and we charge what is usual and customary for our areas. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

REGARDING SECONDARY INSURANCE:
We are not responsible for submitting balances to your secondary insurance companies. We will gladly provide you the information you need to collect from your secondary insurance carrier.

RETURNED CHECK FEE: $50.00

Thank you for understanding our office financial policy. Please feel free to let our billing office know if you have any questions or concerns or if you need to discuss payment arrangements.

I have read the above office financial policy, I agree and understand its terms.

_____
Signature of patient or responsible party Date

_____
Signature of co-responsible party Date