PLEASE PRINT

Date: ________________

PATIENT REGISTRATION INFORMATION

☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr. (CHOOSE ONE!) ________ LAST NAME ________ FIRST NAME ________ MI

Previous Name: ________ (E.G., MAIDEN NAME)

Address: ________ STREET ADDRESS ________ CITY ________ STATE ________ ZIP

Phone – Home ________ Cell: ________ Work: ________ ext ________

Ethnicity: ________ Race: ________

Primary Care Provider: ________ NAME AND CITY

Referring Provider ________ NAME AND CITY (if different than PCP)

Patient date of birth: ________ ☐ M ☐ F ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated 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: ________ LAST NAME ________ FIRST NAME ________ MI Phone: ________

(STATEMENTS WILL BE ADDRESSED TO RESPONSIBLE PARTY)

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

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

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

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

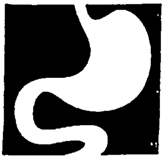
How did you learn of this practice? ________

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 dependants. 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 dependants and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I, ________ (name of insured) herby authorize ________ (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)



GANJ
GASTROENTEROLOGY
ASSOCIATES OF NEW JERSEY

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

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

N101
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 o f 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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Form F102

AUTHORIZATION FOR THE USE AND DISCLOSURE OF MEDICAL INFORMATION

I, ________________, hereby authorize Gastroenterology Associates of New Jersey, LLC to use and/or disclose a copy of my medical records containing individually identifiable health information as described below. I understand that this authorization is voluntary. I also understand that, if the organization authorized to receive the information is not a health care provider or health plan, the released information may no longer be protected by state or Federal privacy laws or this authorization.

Person/Organization Providing the Information:

[Name of Patient or Representative____

____

____

Person/Organization Authorized to Receive the Information:

____

____

____

Specific and meaningful description of the information to be used and/or disclosed (such as dates of service or treatment, type of service or treatment, level of detail to be released or origin of information):

____

____

____

____

____

____

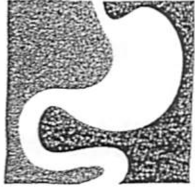
This medical information is being used and/or disclosed for the following purpose(s):

["At the Request of the Individual" is sufficient if the request is made by the patient and the patient does not want to state a specific purpose]

____

____

____



GANJ
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71 Union Avenue · Suite 201
Rutherford, New Jersey 07070
T 973-842-0020 · F 973-842-0010
www.ganjllc.com

Our office is web enabled!

Through the Patient Portal you will have access to appointments, lab results, medications, medical records and much more. Simply provide us with your email address to get started.

Patient Name:____

☐ I consent to being web enable through the patient portal.

EMAIL ADDRESS:____

☐ I do NOT wish to be web enabled.

Gastroenterology Associates of New Jersey, LLC
1130 McBride Avenue | Woodland Park, NJ 07424
Tel. 973-785-2277 | Fax 973-785-2355

CONSENT TO NAME AN AUTHORIZED REPRESENTATIVE TO PURSUE AN APPEAL OF AN ADVERSE BENEFITS DETERMINATION INVOLVING MEDICAL JUDGEMENT &

AUTHORIZATION TO RELEASE INFORMATION RELATING TO THE APPEAL

I, ______________________________, by signing below, agree to representation by the following authorized representative, **Gastroenterology Associates of New Jersey (GANJ)**, to act on my behalf in an appeal of an adverse benefits determination involving medical judgement as allowed by the Patient Protection and Affordable Care Act (PPACA) Public Law 111-148, and Section 2719 of the Public Health Services Act (PHS Act) which PPACA has incorporated into the Employment Retirement Income Security Act (ERISA) and the Internal Revenue Code (the Code), making those provisions applicable to group health plans and health insurance issuers providing health insurance coverage in connection with group health plans. I also agree to the release of my personal health information to my appointed authorized representative named herein, to ___________________________________ and its independently contracted Independent Review Organization (IRO) that will review my appeal. My consent to this appointment of this authorized representative and my authorization of release of my personal health information expires in 24 months, but I may revoke both sooner.

Signature: ______________________________ Ins.ID#__________________

Date:______________________

Relationship to Patient: [ ] I am the patient [ ] I am a personal Representative