PREMIER GASTROENTEROLOGY OF HAMILTON

***PLEASE PRINT ALL INFORMATION. If more room is needed to answer any questions, please use back of form**

PATIENT INFORMATION:

Name: First _____ Last_____ MI____

Address: Street _____ City _____State_____ Zip:_____

Phone: Home _____Cell_____ Work _____
Acceptable to leave a message at the following: Home [ ] Cell [ ] Work [ ]
Sex ____M ____F **Date of Birth** _____ **Soc Sec #:** _____

Marital Status: __Married __Single __Other ___Employed ___Unemployed __Retired __Student FT/PT
Patient's Employer_____ **Occupation:**_____

Primary Physician: _____ Address: _____
City_____ State _____ Zip_____ Phone_____

Emergency Contact: _____ Relation: _____ Phone: _____

Email Address for Appointment Reminders: _____

INSURANCE INFORMATION: **(Please put primary carrier information first)**

PRIMARY INSURANCE:
Name: _____ Policy/ID #:_____

Subscriber Name: _____ DOB:_____
Relationship: _____ SS#: _____

SECONDARY INSURANCE:
Name: _____ Policy/ID #:_____

Subscriber Name: _____DOB: _____
Relationship: _____SS#: _____

PHARMACY INFORMATION:

Name:_____ Phone #:_____
Address:_____
Allergies: _____
Prescription Plan: □ **Yes** □ **No**

Date: _____ _____
Signature of Patient

2271 Route 33, Suite 110, Hamilton, NJ 08690
Phone (609) 917-9917 Fax (609) 570-8161

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PLEASE FILL OUT WHERE MARKED WITH (X):

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information to the physician/entity listed below.

(X) Patient Name:_____ DOB:_____

Radiology reports Laboratory reports Endoscopy reports Colonoscopy reports Progress notes

Release my records to the following physician/entity associated in my medical care:

Shivaprasad Marulendra MD
Punitha Shivaprasad DO
Joshua Weston DO
Premier Gastroenterology of Hamilton
2271 Route 33, Suite 110, Hamilton, NJ 08690
Phone: (609)-917-9917 Fax: (609)-570-8161

(X) Patient Signature:_____

(X) Patient Printed Name:_____

(X) Signature of Patient's Representative_____

(X) Printed Name of Patient's Representative:_____

LEAVE BLANK, ONLY FOR OFFICE STAFF TO FILL OUT:

To:_____Date:_____

Address:_____

Phone: _____ Fax:_____

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Patient Name_____

Date of Birth _____

I wished to be called at home ( ); mobile ( )(**X** to all that apply) regarding my care and follow up.

The best telephone number(s) to reach me is(are):

Home_____ Mobile_____

I do ( ); I do not ( ) give permission to leave relevant medical information on my answering machine or voice mail.

I do ( ); I do not( )want relevant medical information shared with the person who may answer the phone. The name(s) of the individual(s) with whom you may leave pertinent information are:

Name_____

Name_____

Name_____

Patient Signature:_____ Date:_____

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COMMERCIAL INSURANCE AND SELF PAY PATIENTS

Premier Gastroenterology of Hamilton (PGH) will bill your primary and secondary insurance carrier for the services you receive in our office, in accordance with all applicable laws and rules regarding patient privacy and security to ensure the confidentiality and safety of our patient's medical records.

You may receive a bill from PGH for the PROFESSIONAL FEE if:

1) Payment is denied by your carrier..

2) You do not provide information requested by your insurance carrier.

3) Your policy benefits have been exhausted (i.e. you've reached your benefit maximum).

4) Your workers compensation or motor vehicle carrier denies your claim as unrelated.

5) You're insurance carrier mailed payment to you rather than PGH and you did not forward the payment as instructed below.

6) You have an attorney's letter of protection and the case does not settle in your favor.

7) We have had no response from your insurance carrier.

8) We participate with your carrier, you will be billed according to your plans benefit allowances i.e. deductible and co-insurance.

9) We were given invalid insurance at the time of service and precertification/referrals could not be obtained.

10) We were not provided with a referral at your time of service.

PGH does not participate with all commercial insurance carriers. Payment may be made directly to the patient for the professional and facility fee. PLEASE DO NOT DEPOSIT THE CHECK. Endorse the check and forward it with the accompanying explanation of benefits to the address listed above. (Your insurance carrier will inform us that this has occurred.) If you do not turn over the check and the explanation of benefits, you will be responsible for the bill IN FULL.

MEDICARE

PGH is participating in the Medicare insurance program. We accept assignment for your professional fee. To comply with federal regulations, you will be billed and are responsible for payment of your yearly deductible and any applicable coinsurance amounts. If you provide us with secondary insurance coverage information, we will bill that carrier for any balance before billing you.

I agree to the terms and conditions as noted above:

_____

Signature Date

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IMPORTANT PATIENT INFORMATION

RELEASE OF MEDICAL RECORDS

I authorize the office/surgery center to release all or any part of my medical record to (a) hospitals or medical service companies, insurance companies, workers compensation carriers, welfare funds or other organizations or agencies that may be concerned with the payment of costs related to my treatment and (b) any other organization or agency to which the office/surgery center is permitted to release such information under applicable laws. In the event that I am transferred to or admitted to a hospital post procedure or require emergency room care within 24 hours post procedure, I authorize the office/surgery center to obtain a copy of the hospital discharge summary.

IDENTITY THEFT

To prevent identity theft, you will be asked to provide photo identification at the time of admission (e.g. valid driver's license) along with your insurance card. The receptionist at the center will photocopy the identification and insurance card and place a copy in your medical record.

FINANCIAL ARRANGEMENTS

I authorize and direct my insurer or payor to pay directly to the above office any and all benefits up to the amount of my bill, accruing to me in connection with my treatment. I agree that, in consideration of the services that were provided to me, I individually obligate myself to pay the amount promptly in accordance with the regular rates and terms of the office. I understand, therefore, that to the extent permitted under applicable laws and contractual arrangements, I am financially responsible to the office for any amounts not covered by insurance. Furthermore, I understand that my insurer or payor may require certain health services to be authorized before they are furnished to me. I individually obligate myself to pay the account of the office with respect to the services that I choose to receive notwithstanding that my health insurer or payor has refused to give preauthorization for all or any portion of my services.

PRE-CERTIFICATION

Your insurance company will be called to pre-certify your procedure. Please make sure that we have the correct insurance information. It is important to notify us if you have different plans for physician and hospital services.

COLLECTION EXPENSES (MEDICARE EXCLUDED)

Should my account with the office be referred to an attorney or outside agency for collection I will pay all reasonable collection expenses, including attorney fees, associated with the collection effort. I acknowledge that all delinquent accounts will bear interest at the legal rate.

PROFESSIONAL FEES

These are the fees that are billed by your physician for his/her services in performing your procedure. These fees are within the range considered usual and customary for this area. Patient responsibility will vary according to each insurance plan.

For questions regarding your physician bill please contact PGH Billing: 732-248-7700

FACILITY CHARGE

When your procedure is performed at a Surgery Center or Hospital, there might be a facility fee. There is a charge for the use of the procedure room for your procedure. Fees will vary according to the type of procedure that is being performed. Patient responsibility is dependent upon individual insurance plans. You may receive a separate bill from the facility.

ANESTHESIA

A certified anesthesiologist and board certified nurse anesthetist will be participating in your procedure in order to provide comfort and safety. This service will be billed to your insurance company. You may receive a separate bill from the anesthesiologist

PATHOLOGY

If a biopsy is required during the course of your procedure a tissue sample will be sent to the laboratory to be analyzed by a pathologist. You may receive a separate bill from the pathologist.

_____

PATIENT RIGHTS /HIPAA/ ADVANCE DIRECTIVE/ DISCLOSURE OF OWNERSHIP

I acknowledge that I have been given written notification of the following:

NJ Patient Bill of Rights and responsibilities

A copy of the HIPAA privacy regulations

ACKNOWLEDGEMENT OF DRIVING RISKS

I have been informed by PGH that I should not drive for at least 24 hours after completion of my procedure. A responsible adult companion is required upon discharge from Surgery Center/ Hospital for all patients who have received anesthesia. Only patients who do not receive anesthesia/sedation and who meet the discharge criteria may be discharged unescorted.

_____

PATIENT SIGNATURE

The undersigned certifies that this form has been fully explained to him/her and the undersigned is satisfied that he/she understands its contents and significance.

_____ _____ _____

Patient Signature

_____

Patient printed name Date