Hunterdon Digestive Health Specialists New Patient Forms

- Important information about your Endoscopy Procedure and Office Visit
- Patient Responsibilities
- Disclosure of Physician Ownership

Important information about your Endoscopy Procedure:

Thank you for choosing Hunterdon Digestive Health Specialists as your healthcare provider. We are committed to providing you with the best possible medical care. Please understand that payment of your bill is considered a part of your scope of care.

Multiple Bills:

You can expect to have at least two separate charges for the professional fees and another charge for the facility (either one of our freestanding Somerset Ambulatory Surgical Centers located in Somerset or Hunterdon Medical Center in Flemington). In addition, if your procedure requires a biopsy, polyp removal, or other therapeutic technique, there will be additional charges. In such case, you may also receive separate billings from the pathologist and the laboratory. You may also receive separate billing from the anesthesiologist unless conscious sedation is provided by Dr. Sinha.

Insurance Questions:

Your insurance coverage is a contract between you and your insurance company. This means that it is your responsibility to see that your insurance company covers your bill. Our office is not involved in setting your coverage benefits, exclusions; preventative benefits, waiting periods, or determining if a referral is needed. Coverage and/or benefit issues can best be addressed by your employer, group plan administrator, or insurance carrier directly. You also agree to pay and portion of the charges not covered by insurance. **If your insurance company requires a Referral, you are responsible for obtaining it and presenting it at the time of service.** If you do not bring a referral, you will be expected to pay at the time of service.

The nature of the diagnosis that has led to your procedure is best discussed with your provider at Hunterdon Digestive Health Specialists. Many insurance plans have separate benefit categories for screening (routine and preventative services) versus medical procedures done due to symptoms or medical history. Based on findings during your procedure, a planned screening diagnosis may become a medical diagnosis if polyps are found or biopsies are taken. For this reason, we strongly suggest that you verify both kinds of coverage when talking with your insurance carrier.

Should you have questions after talking with your insurance company, please call our office prior to your scheduled procedure; they can be reached at (908)788-8200. We do not change the coding of the procedure after it is billed, so please ask us questions prior to your procedure.

Patient Signature: ______________________________ Date: ___________________________

Cancellation Fees:

To avoid cancellation fees please notify our office of any appointment cancellations forty eight (48) business hours prior to your office visit and fourteen (14) days prior to your procedure. Failure to do so may result in the following fees:

- Office Appointment - $25
- Procedure Appointment - $100

Initial: ___________________

Cancellation policies:

Hunterdon Digestive Health reserves the right to cancel or reschedule your office visit and procedures. If a medical clearance is required, it is the patient's responsibility to provide us with the clearance at least two (2) weeks prior to the procedure otherwise the procedure will be cancelled or rescheduled.

Expenses:

Once your insurance company has paid, denied, or otherwise processed your claim (i.e applied to deductible, co-pay, etc) payment is due upon receipt of your first statement, unless other payment arrangements are made. We accept credit cards, cash, and checks.

Payment:

Co-payments required by your insurance company must be paid at the time of service. Because this is an insurance requirement, we **cannot** bill you for these services.

Monthly Statements:

If you have a balance on your account, we will send you a monthly statement. Unless other arrangements are approved by us in writing, the balance on your account is due and payable when the statement is issued. Any personal balance over thirty (30) days old without current payments applied against it is considered an overdue balance resulting in delinquent status of the account. To avoid assignment to a professional collection agency, all payments due should be made promptly. If **genuine financial difficulties exist,** please **call**. We are happy to arrange a personalized monthly budget payment plan.

Returned Check Policy:

There is a fee, currently $25, for any checks returned by the bank.

Signature: ____ Date:_________________________

Laboratory/Radiology Testing:

It is the patient's responsibility to know what lab or testing location is covered by their insurance plan. Hunterdon Digestive Health is not responsible for any balance incurred from other facilities.

Disclosure of Ownership:

Federal and state law requires we disclose our financial interest in the Ambulatory Surgery Center of Somerville.

Name of Physician Owners: Anubha Sinha, MD

Patient Signature: _________________________________ Date:_______________________

Patient Responsibilities:

- The patient is responsible to provide our health care providers with all the information about any past illnesses, hospitalizations, medications, and other health matters.
- The patient/and or family are responsible for asking questions when they do not understand instructions or explanations given by the health care provider and/or staff.
- The patient is responsible for keeping appointments as scheduled and to telephone the office in case of a cancellation.
- The patient is responsible for providing his/her insurance information, and assuming the financial obligations of his/her care are fulfilled as promptly as possible.
- The patient is responsible to follow the health care provider's instructions and plans of treatment and the patient is responsible for the consequences if he/she refuses treatment or fails to follow the practioners instructions.
- The patient is responsible for being respectful and considerate to other patients and organizational personnel.
- The patient is responsible to discuss consequences of leaving against medical advice with their physician.
- The patient is responsible for communication of questions, concerns, or needs.

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 medication 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 to receive another test including, but not limited to, a blood test, MRI, or a CT scan, this timely recommendation is important and essential to 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 my sole responsibility to follow any of the medical advice given to me 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 _______________

Hunterdon Digestive Health Specialist

New Patient Registration

If you are a new patient to Hunterdon Digestive Health, please take a few minutes to complete our on-line registration. When you have completed the forms, please print this registration. It is very important you bring the completed registration with you to your first appointment.

Patient Information:

Last Name ________________________________First _________________________ MI_______
Address____
City ____ State__________ Zip______________________
Home Phone______-_________-___________ Cell_______-________-___________
Business Phone_______-________-_________
Social Security Number______-______-______ Sex M____F____ Birth Date_______/_______/_______
Name of insurance_________________________ ID
____________________________Group_______________
Email Address _______________________________________
Employer Name ______________________________________
Occupation ____
Marital Status: Single____ Married____ Divorced ____ Widowed ____ Separated____ Widowed____
Other____
Name of Primary Physician __________________________________
Name of Referring Physician ___________________________________
Name of Emergency Contact_____________________________________
Phone Number _______-_______-_______
How did you hear about us? ______________________________________
If your insurance is in someone else's name other than yourself, we need:
Name of Subscriber – Last Name ________________________ First Name ________________________
Relationship____________________________ Date of birth ______-______-______
Address____
____
Home Phone _______-_______-________ Business Phone ______-______-_______
Social Security Number ______-______-_______ Date of Birth ______/________/_______
Employer____
Occupation____
Please present your insurance card to receptionist after completing this form along with valid ID

Should inaccurate or omitted insurance information be supplied causing a reduction or non-payment of benefits, the obligation of payment will be transferred to the responsible party. I hereby authorize the release of any medical information necessary for processing of insurance. I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled to Hunterdon Digestive. This assignment will remain in effect until revoking me in writing. A photocopy of this assignment, or electronic copy, is to be considered as valid as an original.

I agree

Patients Name _______________________ Signature ________________________ Date ____/___/____

Patients Name: ______________________________

Procedure: _________________Procedure Date: ____________
Procedure Time: ______________
Arrival Time: _________________

Hunterdon Digestive Health Office: 170 Route 31 Flemington, NJ 08822 (908)-788-8200 Medigain Billing (855)-299-6594 (201)-735-8620	Hunterdon Medical Center Business Office-Procedure 2100 Wescott Dr, Flemington, NJ 08822 2nd Floor of Hospital Pathology: (908)788-6407 Endoscopy: 908-788-6439 Anesthesiologist: (908)237-0403 Pre-Registration: (908)-788-6167 (1 week prior to procedure) ATC Clearance: (908)-788-6666 (at least 2 weeks prior to procedure)	Somerset Ambulatory Center: (908)-393-8360 1 Highway 206 North Somerville, NJ 08876 Administrator - Larry Pecora Robert Wood Johnson Pathology: (732)-499-6139 Anesthesia Consultants: (732)-271-1400

Follow up Date: ________________________ Follow Up Time: ________________________

Hunterdon Digestive Health Specialists, P.A
Anubha Sinha, M.D
Gastroenterology and Hepatology

ACKNOWLEDEMENT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have been offered a copy of Hunterdon Digestive Health Specialists Notice of Privacy Practices and that Hunterdon Digestive Health Specialists may use and disclose my health information as described in the notice.

ACKNOWLEDGMENT OF NOTICE OF PATIENTS'S RIGHTS

I hereby acknowledge that I have been offered a written copy of the "Rights of Each Patient" adopted by the New Jersey Department of Health for ambulatory care facilities and a written or verbal explanation of these rights.

RELEASE OF INFORMATION

I hereby give my permission for representatives of HUNTERDON DIGESTIVE HEALTH to release or discuss my Protected Health Information (PHI) with the following individual(s):

This disclosure may include disclosure of information relating to:
Must initial next to the following:

________Genetic Testing
________STDs
________AIDS/HIV
________Behavioral/Mental Health Information
________Psychotherapy Notes
________Alcohol/Drug Abuse
________Tuberculosis

Relatives: NAME/DOB/RELATIONSHIP: ____
NAME/DOB/RELATIONSHIP: ____
Physician(s): NAME/PRACTICE: ____
NAME/PRACTICE: ____
Other: NAME/DOB/PRACTICE:____

Please indicate how you wish us to reach you:

1st Phone # Preference: ____________________________ OK to leave a detailed message?__________
2nd Phone # Preference: ___________________________ OK to leave a detailed message?__________

I further acknowledge that I understand the explanation given to me about my rights.

____ __________________
Print Name of Patient (or Personal Representative) Date

____ _________________________________
Signature of Patient (or Personal Representative) Relationship of Personal Representative

**ATTENTION: The patient reserves the right to revoke this authorization at any time in writing by completing a new HIPPA form provided by HDH to implement any future changes. This completed HIPPA will remain valid until future written changes are submitted to HDH.