NORTH JERSEY GASTROENTEROLOGY & ENDOSCOPY ASSOCIATES, PA
Registration Form

NAME _____
LAST FIRST MIDDLE

STREET _____

CITY _____ STATE_____ ZIP CODE _____

HOME PHONE _____ JOB PHONE_____ CELL PHONE _____

EMAIL - _____

DATE OF BIRTH _____ SOCIAL SECURITY #_____

RACE ☐ White ☐Asian ☐ Black ☐ American Indian ☐ Hispanic ☐Other ☐Refused

ETHNICITY ☐ Non-Hispanic ☐Hispanic ☐ Refused

PRIMARY CARE PHYSICIAN _____ REFERRING PHYSICIAN (if different) __ _____

PHARMACY NAME _____ MAIL ORDER PHARMACY NAME _____

PHARMACY TOWN _____

MEDICARE: ☐ YES ☐ NO If Yes, Number _____

☐ I allow the physicians of North Jersey Gastroenterology to review the prescriptions previously filled at my pharmacy/ pharmacies. _____

PRIMARY INSURANCE _____

POLICYHOLDER NAME _____ ADDRESS _____

POLICYHOLDER DATE OF BIRTH _____

PATIENT RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

SECONDARY INSURANCE _____

POLICYHOLDER NAME _____ ADDRESS _____

POLICYHOLDER DATE OF BIRTH _____

I hereby authorize and guarantee payment for all services rendered:

I authorize any holder of Medical or other information about me to release to the Social Security Administration and the Centers for Medicare and Medicaid Services (CMS) or its intermediaries or carriers, or to the billing agent of this physician, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

☐ *If patient is a Medicare Recipient:*
I request that payment of authorized Medicare benefits be made to me or on my behalf to North Jersey Gastroenterology & Endoscopy Associates, PA for services furnished to me by the provider. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits payable for related services.

☐ *If patient is a Medicaid Recipient:*
I request that payment for all services be made directly to this doctor on my behalf. I authorize any holder of medical or other information about me to release to the Division of Medical Assistance and Health Services or its authorized agents any information needed for this or any related claim. I also agree to pay any amount Medicaid did not or will not pay because I was ineligible to receive Medicaid benefits or services were outside of program limitations.

☐ *If patient is covered by health insurance in which the practice participates:*
I request all payments be made to this doctor directly for covered services. I agree to pay any non-covered service which my insurance company will not pay as well as my co-pay or deductible as applicable.

☐ Medigap Waiver:
I requested that payment of authorized Medigap benefits be made either to me or on my behalf to the provider of service and/or supplier for any services furnished to me by the provider of service and/or supplier. I authorize any holder of Medicare information about me to release any information needed to determine these benefits payable for related services to my Medigap insurance.

Signature: _____ Date:_____

Privacy Notice

I acknowledge that I have been provided with a copy of North Jersey Gastroenterology and Endoscopy- Associates/ Center privacy notice and have been given an opportunity to read and ask questions about the notice.

Patient signature: _____ Date: _____

HIPPA Acknowledgment

Health Insurance Portability and Accountability Act of 1996

I understand that reports generated by this office will be sent to my physician/physicians.

____ **I WANT** to have my biopsy or test results left on my **personal cell phone voicemail.**

___ **I DO** / ___ **DO NOT** want to have my biopsy or test results left on my **home voicemail.**

____ **I authorize** the release of my HIPPA confidential information to the following family members or friends:

1. Name:_____ Relationship:_____
   Phone: _____

2. Name:_____ Relationship: _____
   Phone: _____

Patient signature: _____ Date: _____