NJ Gastroenterology Health & Wellness

2626 Tilton Rd, Egg Harboor_Township, NJ 08234
16 S Rhode Island Ave, Atlantic City, NJ 08401
639 Teaneck Rd, Teaneck, NJ 07666

Phone: 609 382 0111 Fax: 201 255 0668
201 710 7733

PATIENT REGISTRATION FORM

Please PRINT in INK

DATE: ______________________

Name ________________________________ Preferred Name ____________________________
Last First MI

Date of Birth ____/____/____ Social Security # _____ --______-- ______
Sex: Male/Female/______________

Address: ____
Street City State Zip

Home Phone: ____________________ Cell Phone: __________________ Work Phone ________________
Email: ________________________

Marital Status: Single Married Widowed Separated Divorced Not applicable
____

Spouse's/Partner's Name: ____

Race: American Indian/Alaska Native Asian Native Hawaiian/Other Pacific Black or African American Caucasian Hispanic Other Race Do not wish to answer
Ethnicity: Hispanic or Latino Not Hispanic
Primary Language: ____________________________

Employment
Employer: ___________________________________ Full Time Part Time
Retired
Student
None
Occupation: ____

Address: ____ Phone # ____________________

Physician/ Pharmacy Information:

Primary Care Physician: ___________________________________ Phone # ____________________

Address:
____

Referring Physician:
____ Phone#: ____________________

Address: ____

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PATIENT REGISTRATION FORM

Preferred Pharmacy: ____ Phone ________________________

Address:
____

Responsible Billing Party

__________ ***Please check if Responisble Billing Party is the patient.***

Name: ____ Date of Birth: ___/___/___
Last First MI

Address: ____
Street City State Zip

Social Security #: _____-____-_____ Phone #: ______________________

Relationship to patient: Self Spouse Partner Other: ________________________________
Please specify

PRIMARY Insurance Information:		
Insurance Name:		
Subscriber's Employer:		
Policy Holder Name:		Date of Birth:
Social Security #: _____-____-_____	Member ID #:	Group #:

SECONDARY Insurance Policy (if any)		
Insurance Name:		
Subscriber's Employer		
Policy Holder Name:		Date of Birth:
Social Security #: _____-____-_____	Member ID #	Group #:

TERTIARY Insurance Policy (if any)	
Insurance Name:	
Subscriber's Employer	
Policy Holder Name:	Date of Birth:

Social Security #: ____-____-____	Member ID #	Group #:

PATIENT REGISTRATION FORM

EMERGENCY CONTACT:	
NAME:	TELEPHONE#:
RELATIONSHIP TO PATIENT:	

The Undersigned patient or individual acting on behalf of the patient agrees that the above facts are correct.

*X____ ____

Patient or Representative of Patient Relationship to Patient Date

____ ____________________

Witness Date

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ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

I hereby give permission to NJ Gastroenterology Health and Wellness to bill my insurance company for professional medical services rendered. I agree to pay all charges due or that become due to NJ Gastroenterology Health and Wellness for the care and treatment provided to me by NJ Gastroenterology Health and Wellness

I understand that insurance benefit verification and authorization is not a guarantee of payment and if the charges are denied, the medical charges will become my responsibility and obligation. I am responsible to pay all copayments, coinsurance and deductible applied to my account after the insurance payment is made and/or the claim is processed.

In addition, any charges denied by the insurance company because they do not meet the criteria for medical necessity would be my responsibility.

And if I do not or did provide NJ Gastroenterology Health and Wellness with accurate and current information regarding my insurer, I will be personally responsible for the cost of the care rendered.

I agree that all bills are to be paid when presented or in advance of treatment, itself pay. And if I fail to pay my bill, I realize that my account with be forwarded to the collection agency and attorney and court fees will be added to my due balance.

*X____
Signature of Patient or Legally Authorized Representative Date

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES
ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge receipt of NJ Gastroenterology Health and Wellness ' Notice of Privacy Practices. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

If you have any question regarding NJ Gastroenterology Health and Wellness ' Notice of Privacy Practices, please contact out Privacy Office at 1-609-382-0111.
I acknowledge receipt of NJ Gastroenterology Health and Wellness Notice of privacy practices

*X.____
Signature of Patient or Legally Authorized Representative Date

FOR OFFICE USE ONLY
INABILITY TO OBTAIN ACKNOWLEDGEMENT

Attempts have been made to obtain written acknowledgement of receipt of Pulmonary Health Consultants' Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Barrier(s) to communication prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining the acknowledgement
- Other (Please specify)____

*X____
Signature of Provider Representative Date

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CONSENT FORM FOR THE AUTHORIZATION OF TREATMENT & RELEASE OF INFORMATION

Name: ____ Date: ______________________
Date of Birth: ______________________________________ MRN#: _____________________

Consent for Medical/Surgical/ Urgent Care
I hereby authorize NJ Gastroenterology Health and Wellness to provide initial and ongoing medical/surgical treatment tha is necessary and reasonable as based on acceptable standards of care for my wellness and the treatment of my physical condition.

I consent to examination, blood tests, (including blood tests for communicable disease such as Hepatitis and HIV/AIDS when healthcare personnel have been exposed to my blood and/or body fluids), laboratory procedures, medications, infusions, nursing care and other services or treatments rendered by my physician, consulting physician, and their associate and assistants, or rendered by facility personnel under the instructions, orders and direction of such physician(s).

Authorization to Release Medical Information
I hereby authorize NJ Gastroenterology Health and Wellness to release information obtained in the course of my medical/surgical/urgent care to my insurance carrier and other providers of health care and healthcare organizations involved in my care. In the event of an employee blood or body fluid exposure, I authorize NJ Health and Wellnss to release pertinent testing for the treatment of the employee. I also authorize NJ Gastroenterology Health and Wellness to receive my medication history

Assignment of Benefits
I hereby assign all medical/ surgical/ urgent care benefits to which I am entitled, including major benefits, Medicare, private insurance and any other health plans, to NJ Gastroenterology Health and Wellness A photocopy of this assignment is to be considered as valid as the original.
I understand that I am financially responsible for all costs not covered by my insurance plan (s). This includes but not limited to co-pays, coinsurances, deductibles, and non-covered procedures and/or diagnoses. I understand that if my insurance requires a referral for me to receive treatment here that is my responsibility to obtain that referral from my primary care physician. I also understand that I am expected to make payment for previous balances or balances sent o collections prior to my office visit. If I am unable to pay my balance in full, I understand that I can speak to the office manager to setup a payment plan.
I understand that NJ Gastroenterology Health and Wellness reserves the right to impose a fee for un-cancelled (failure to show)
appointments.

Consent to Call, Text, or Email
I consent to receiving the following automated communications from NJ Gastroenterology Health and Wellness
Health Notifications [ ] Email [ ] Phone [ ] Text Message
Appointments [ ] Email [ ] Phone [ ] Text Message
Announcements [ ] Email [ ] Phone [ ] Text Message
Billing [ ] Email [ ] Phone [ ] Text Message

If email was chosen as a communication preference above, please provide your email address:
____

I authorize the release of information including the diagnosis, records and examinations rendered to me as well as claims information, to the persons listed below:
Name ____ Relationship ____________________
Phone Number ___________________
Name ____ Relationship ____________________
Phone Number ___________________
[ ] Check here if you DO NOT want this information release to anyone other than yourself

Patient or Legal Representative Signature: *X______________________ Date ______________
Relationship to Patient: ______________________________
Witness: ______________________________________ Date: ______________

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act –45 CFR Parts 160 and 164)
1. I hereby authorize all medical service sources and health care providers to use and/or disclose the protected health information ("PHI") described below to my agent identified in my durable power attorney for health care named

____.

2. Authorization for the release of PHI covering the period of health care (check one)
a. _____ from (date) _______________- to (date) _______________ OR
b. _____ all past, present and future periods.
3. I hereby authorize the release of PHI as follows (check one)
a. ____ my complete health record (including records relating to mental heath care, communicable disease, HIV or AIDS, and treatment of alcohol/drug abuse). OR
b. ____ my complete health record with the exception of the following information (check as appropriate):
____ Mental health records
____ Communicable disease (including HIV and AIDS)
____ Alcohol/drug abuse treatment
____ Other (please specify): __________________________
4. In addition to the authorization for release of my PHI described in paragraphs 3a and 3b of this Authorization, I authorize disclosure of information regarding my billing, condition, treatment and prognosis to the
following individual(s):
Name ______________________________ Relationship ______________________________

Name ______________________________ Relationship ______________________________

Name ______________________________ Relationship ______________________________

5 This medical information may be used by the persons I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
6. This authorization shall be in force and effect until nine (9) months after my death or _____________, (date or
event) at which time this authorization expires.
7. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization
or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right
to contest a claim.
8. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
9. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.
*X____ Date: ______________
Signature (18 years or older)
*X____ Date ______________
Signature of Legal Representative Relationship to Patient
Keep original, and give copies to your health care provider, agent and family members

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CANCELLATION / NO SHOW POLICY

Thank you for entrusting your medical care with Pulmonary Health Consultants.
When you schedule an appointment with Pulmonary Health Consultants, we set aside enough time to provide comprehensive and higher quality of care.
We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family.
Should you need to cancel or reschedule an appointment, please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment.
This gives us time to schedule other patients who may be waiting for an appointment and reschedule yours as well.
Thank you for understanding and your cooperation as we strive to best serve the needs of all our patients.
By signing below, you acknowledge that you have received this notice and understand this policy.

____
Printed Name Date
*X____
Signature

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REQUEST FOR RELEASE OF HEALTHCARE INFORMATION

Patient Name:_______________________

Today's Date:_______________________

Last 4 digits of SSN:_________________

Date of Birth:_______________________

I hereby authorize:____

Address:____

Phone:_____________________________

Fax:_______________________________

To release, use, and disclose health information about me as described below to:

This request and authorization applies to :

[ ] All Healthcare information

Patient Signature: X____

Date Signed:_________________________

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TREATMENT CONSENT FORM

* Billing & Payments
* Treatment Fees
* Client Bill of Rights
* Out Of Network Practice Status
* Sessions
* Referrals
* Medications / Receiving medication history
* Legal Fees / Professional Services
* Summary of Medicare Acceptance
* Contacting Us
* Insurance Reimbursements
* COVID- 19 Informed consent
* Confidentiality
* Client Grievances
* Privacy Practices
* Introduction / Psychotherapy
* Cancellation / No-Show Policy
* No Harm Contract / Video Surveillance
* Injections / Testosterone Replacement
* Consent to receive appointment reminders (voice/text)
* Professional Records
* Assignment & Release of Benefits
* Tele-medicine
* Minor Child Treatment Consent

Your signature below indicates you have read the treatment consent and are aware you can receive a copy if requested, which contains information on clinical services, professional fees, cancellation and no show policies, billing and payments, insurance reimbursement, authorization and release of benefits, contacting us, professional records, no harm contract, client bill of rights, client grievances, policies, confidentiality, Medicare acceptance, appointment reminders, out of network status, video surveillance, referrals, minor child consent, and medications/testosterone replacement / injections, and you agree to abide by its terms during our professional relationship. For minor children, please initial the line below in addition to signing this form.

Name of Patient (printed):

________________________________ **Date:** ________________

Signature of Patient (or legal guardian): **X** ____

PROVIDER: New Jersey Gastroenterology Health and Wellness / Brian Berberian MD

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ASSIGNMENT AND RELEASE OF INSURANCE BENEFITS

I certify that I, and/or my dependents, have insurance coverage with: ________________ and assign directly to New Jersey Gastroenterology Health and Wellness all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance. I authorize the use of my signature or the signature of my dependents on all submissions.

I, the undersigned, hereafter referred to as "the patient" do hereby assign all of my rights and interest to New Jersey Gastroenterology Health and Wellness, hereafter referred to as "the medical provider" to pursue and obtain payment from the above named Insurance carrier. I, assign to the medical provider, all my rights and benefits under the Insurance contract for payment for services rendered to me. I, the patient, do hereby understand and acknowledge that if I refuse to comply with reasonable requests of the Insurance carrier, any denied claims I will be held responsible for same. I, the patient, do hereby direct my health insurance carrier and/or other insurance carrier to issue payment on my behalf directly to the medical provider. The check should be made payable to the medical provider. Further, in the event that the health carrier and/or other Insurance carrier fails to forward the check to the medical provider, I will endorse and sign the check to the medical provider within (5) five days of the receipt of same. I, the patient, do hereby acknowledge that I will not file suit and/or arbitration for the payment of the above provider's medical bills. I understand that the above referenced medical provider has an attorney and will collect payment on my behalf from the insurance carrier or from me if I fail to pay. To prevent the Insurance carrier and/or the vendor designed by the Insurance carrier from refusing to accept my Assignment or submitting challenge to my Assignment as being Invalid, I execute this Special Power of Attorney to appoint and authorize the medical provider and counsel on behalf of the medical provider to file suit and/or arbitration directly against the insurance carrier in my name. This Assignment serves as a limited retained agreement between me and the chosen attorney by the medical provider for the sole purpose of representing me on a claim for outstanding treatment. The above-named Care Center/Physician(s) may use my health information and may disclose such information to the above-named Insurance Company (companies) and their agents for the purpose of obtaining payment for related services.

I also acknowledge that if I do not provide benefit checks received by me within 30 days of the confirmation of checks being sent to me, my credit / debit card provided on intake will automatically be charged for the visit.

Patient Name: ______________________________

Signature of Patient (or legal guardian): ______________________________

Date: ______________________

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CREDIT OR DEBIT CARD TO KEEP ON FILE

Please be advised that a credit/debit card is **required** regardless of insurance coverage/method of preferred payment due to the office's late cancellation / no show policy.

Patient's Name: ______________________________ **Date of Birth:** ____________________

Type of Card: _______ VISA _______ MC ________ AMEX ________ DISCOVER _______ OTHER

Name on Card: ____

Card Numbers: ____

Expiration Date: _________

Security Code: _________

Zip Code: __________

How would you like your receipt? __________ TEXT __________ EMAIL

Cell Phone: ______________________ Email Address: _________________________

____

Signature

All payments are collected at time of service and are non-refundable. Signature on receipt is legally binding that service was rendered and patient waives right to dispute charges with their bank. Any disputes must take place within 7 days or patient waives their right to dispute charges. A $75 fee will be charged for administrative time spent on any credit card disputes. All services are non-refundable. If there is a question regarding a charge, contact the office for resolution to avoid a fee for administrative time spent responding to dispute. I acknowledge if I dispute a claim NJGHW has the right to release my PHI to square for the purposes of disputing the claim. I have authorized NJGWH to charge my card or any future credit cards provided for services rendered / fees incurred. I understand all charges are nonrefundable and that I'm charged at the time of service. I understand my card will be stored for future transactions. I acknowledge there may be a processing fee involved for credit card charges.

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Acknowledgement of Procedure for Scheduling and Medication Refills

Please read each statement and sign below.

I am responsible for calling the office to schedule my follow-up appointments. _X_

I am responsible for giving a 24-hour notice to cancel/reschedule my appointment. If I do not cancel in advance or if I do not show for my appointment, I agree to pay a fee of $100.00-$180.00. _X_

I understand that my medications will **not** be refilled without speaking to my provider during my scheduled appointment. _X_

I understand that I am responsible for informing the office staff of any changes to my insurance and/or payment information prior to scheduling an appointment. _X_

I understand (if applicable) that my medicinal marijuana script will only be renewed during my scheduled appointment with Brian Berberian,MD_X_

I understand and agree to the terms listed above.

Name of Patient: ____________________________

Signature of Patient (or Parent/Guardian): ________________________

Date: ____________

Failure to comply with these procedures may result with discharge from the practice and liability for all balances owed.