

Shore Gastroenterology Associates, PC

Last Name _____ First Name _____ M.I. _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Date of Birth _____ SS# _____ Marital Status: S M D W

Email address _____ How did you hear about us? _____

Primary Care Physician _____ Phone # _____

Allergies: _____

EMPLOYER INFORMATION

Employer _____ Occupation _____

Address _____ City _____ State _____ Zip _____

PRIMARY INSURANCE

Policy Holder _____

Employer _____

Insurance Co _____

Policy# _____ Grp# _____

Social Security# _____

Date of Birth _____ Sex _____

Relationship to Patient _____

SECONDARY INSURANCE

Policy Holder _____

Employer _____

Insurance Co _____

Policy# _____ Grp# _____

Social Security# _____

Date of Birth: _____ Sex _____

Relationship to Patient _____

EMERGENCY INFORMATION

Who may we contact in case of emergency? _____ Relationship _____

Home Phone _____ Cell Phone _____ Work Phone _____

ASSIGNMENT AND RELEASE OF INFORMATION STATEMENT

I hereby authorize my insurance carrier to make payment directly to Shore Gastroenterology Associates, PC for services rendered to me or my dependents. I understand that I am fully responsible for any charges incurred for services rendered as well as as any third-party costs or fees incurred for collection of this account. I authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or my dependents. I have received a copy of and agree to abide by the Financial Policies of Shore Gastroenterology Associates.

PATIENT NAME _____

RESPONSIBLE PARTY _____ RELATION TO PATIENT _____

SIGNATURE OF RESPONSIBLE PARTY _____ DATE _____

Shore Gastroenterology Associates, PC

FINANCIAL POLICY

We are pleased that you have chosen Shore Gastroenterology Associates for your healthcare needs. It is our goal to provide you with the highest quality healthcare services possible. In choosing our services, you have accepted the financial responsibility to ensure full payment for our services.

OUR POLICY REGARDING:

Copayment: Your copayment, as stated on your insurance card, will be collected from you prior to your visit. You may make your payment either by cash, check or credit card. We gladly accept Visa, MasterCard, American Express, and Discover cards for payment.

Private Pay: Patient agrees to pay Shore Gastroenterology Associates at the time of treatment for services rendered. We will provide a statement which can be used to submit claims for reimbursement or kept for personal records.

Medicare: Shore Gastroenterology Associates is a participating provider with Medicare Part B program. We will bill Medicare directly for services rendered. You will be responsible for any deductibles and coinsurance.

Medicaid: We do not participate in the Medicaid program; therefore you are personally responsible for payment of our services.

HMO/PPO/POS: Our office participates in many HMO, PPO, and POS plans. You are responsible at the time of service for any copayment stated on your insurance identification card. Any additional amounts due by you will be billed to you once your insurance processes the bill.

Major Medical: Your major medical insurance coverage is a contract between you and your insurer. As a courtesy to you Shore Gastroenterology will bill your insurance carriers directly. You are responsible for any deductible and co-payment or coinsurance that is determined by your insurance carrier.

Workers' Compensation: Shore Gastroenterology Associates will bill your insurance carrier for you. Should your claim be found to be non-compensable, we will bill your private health insurance carrier, and you will be responsible for any applicable co-payment or coinsurance.

Motor Vehicle Accident: Shore Gastroenterology Associates will bill your motor vehicle and health insurance(s) directly. Should your motor vehicle insurance deny your claim, we will send your bill to your private health insurance carrier. You will be responsible to pay for patient responsibility as stated by your health insurance. It is not our policy to await the results of your litigation to receive payment; we will not hold a Letter of Protection or Lien on your account. We do not waive any financial responsibility in litigation cases.

Referrals/Authorizations: You are responsible for obtaining a referral or authorization as required by your insurance for our services. You may be financially responsible for any charges denied due to absence of a referral or authorization. Your scheduled visit may also be rescheduled due to the absence of a referral/authorization; or you may choose to pay your visit in full, and be reimbursed upon presentation of a valid referral/authorization.

Cancellation Policy: If you fail to call and cancel your appointment, we reserve the right to bill you a cancellation fee of \$25.00 which your insurance company will not pay.

Returned Checks: If your personal check is returned to us by your bank for any reason, you will be charged a fee of \$25.00. Both your original payment and check fee are payable in cash or credit card. Any future payments you need to make to our office must be either cash or credit card.

Shore Gastroenterology Associates, PC

CONSENT FOR USE AND DISCLOSURE OF PRIVATE HEALTH INFORMATION (PHI)

Use and Disclosure of your PHI

Your PHI will be used by Shore Gastroenterology, or disclosed to others, for the purpose of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Notice of Privacy Practices

You should review our Notice of Privacy Practices for more complete description of how your health information may be used or disclosed. A copy of this notice will be provided to you upon your request.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your protected health information. Shore Gastroenterology may or may not agree to restrict the use or disclosure of your PHI.

If Shore Gastroenterology agrees to your request, the restriction will be binding on the practice as a whole. Unauthorized use and disclosure of protected information is a violation of an agreed upon restriction, and will be a violation of federal privacy standards.

I give my consent to be contacted in the following manner:

	<u>Home</u>	<u>Work</u>	<u>Cell</u>
It is OK to Contact me at:	Y / N	Y / N	Y / N
It is OK to leave a basic message at:	Y / N	Y / N	Y / N
It is OK to leave a detailed message at:	Y / N	Y / N	Y / N

Please list people we may speak to other than you:

Revocation of Consent

You may revoke this consent to the use and disclosure of your PHI at any time. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices

Shore Gastroenterology reserves the right to modify the privacy practices outlined in the notice.

Signature

I have reviewed this consent form and hereby give my permission to Shore Gastroenterology to use and disclose my PHI in accordance with these guidelines.

Patient Name: _____

Signature of Patient or Patient Representative **Date**

Shore Gastroenterology Associates, PC

BLOOD WORK AND LABORATORY PROCEDURE POLICY

Blood Draw

You are exempt from this service fee if you have Medicare or Aetna.

As a convenience to our patients, Shore Gastroenterology provides the option of having blood drawn in our office. Blood drawn in our office is completely voluntary and is offered as an alternative to making a trip to your insurance designated lab. However, your insurance carrier will not pay for us to draw blood in our office. Therefore, the purpose of this form is to help you make an informed decision about whether or not you want to receive this service here in our office.

Before making your decision, please read the following options:

Option 1, YES I want to receive these services. I understand that my insurance will not pay for me to have blood drawn at Shore Gastroenterology. I agree to pay a fee of \$10.00, payable today, to have my blood drawn during my visit. I further understand that I will NOT receive a receipt for this service to file with my insurance carrier.

I understand that this is for the drawing of blood only. The blood work will still be sent to an outside lab for processing. My insurance carrier will be billed directly by the lab for the actual tests performed on the blood.

Option 2, NO I have decided not to receive this service. I will not have my blood drawn at Shore Gastroenterology. I further understand that I will be given a lab requisition to take to the nearest LabCorp or Quest drawing station to have my blood drawn. I understand that it is important that I take the lab requisition with me when going to the draw station so that my results will be sent directly to Shore Gastroenterology.

Laboratory Testing

Some insurance companies restrict the patient's use of laboratories to only "designated" laboratories. Therefore, YOU must advise us of where you/your insurance company want your blood work and other pathologies to be processed. We will not be responsible for any charges incurred for tests sent to a lab that is not in network for your insurance. The laboratory will bill your insurance carrier directly for their services.

Insurance Company _____ Designated Lab _____

Under certain circumstances, your insurance carrier may not cover the cost of certain tests. We will provide you with the opportunity to find out the cost of specific tests if desired. Although we try to be familiar with the major insurance plans, it is not possible for us to know what each insurance plan will cover. Insurance companies may reimburse differently for tests. Some tests require pre-certification or authorization, which you will be responsible to obtain.

I agree to be personally responsible for payment and to hold Shore Gastroenterology Associates harmless for any charges in the event my insurance carrier denies payment for any reason. I agree that I will be personally responsible for any charges that a laboratory bills to Shore Gastroenterology Associates for clinical tests performed on my behalf.

Signature of Patient or Patient Representative

Date