新泽西消化内科中心

NEW JERSEY DIGESTIVE DISEASE ASSOCIATES

247 BRIDGE STREET, BUILDING G
METUCHEN, NJ,08840

29 COLUMBIA TURNPIKE, SUITE 202
FLORHAM PARK, NJ, 07932

TEL:732-662-5115 FAX 732-362-4619 www.njdda.com Email: njddageneral@gmail.com

病人登记表

PATIENT REGISTRATION FORM

❄必须填写项目 ❄要求签名处

注意：您可以将填好的表格与要求的附件通过以下方式提交：电子邮件(njddageneral@gmail.com)，传真(732-362-4619)，邮寄(247 Bridge Street, Building G, 08840) 或当面提交.

病人姓名 （英文或拼音与保险卡一致）

❄ 姓 LAST NAME	❄ 名 FIRST NAME	❄ 出生日期 DATE OF BIRTH

❄ 性别 SEX ☐ 男 MALE ☐ 女 FEMALE 婚姻状况 MARITAL STATUS ☐ 未婚 SINGLE ☐ 已婚 MARRIED ☐ 其他 OTHER

家庭住址

❄ 街道 STREET	❄ 城市 CITY	❄ 州 STATE	❄ 邮编 ZIP
❄ 手机 CELL PHONE	家庭座机 HOME PHONE	❄ 电子邮件 EMAIL	

紧急联系人

关系 RELATIONSHIP	姓 LAST NAME	名 FIRST NAME	手机 CELL PHONE

保险信息

❄ 主要保险公司名称 NAME OF PRIMARY INSURANCE

❄ 保险卡号 POLICY NUMBER GROUP NUMBER

❄ 主要受保人SUBSCRIBER OF PRIMARY INSURANCE ☐ 本人SELF ☐ 配偶 SPOUSE ☐ 父母 PARENT ☐ 其他 OTHER

主要受保人若非本人，请填写以下信息

❄ 姓 LAST NAME	❄ 名 FIRST NAME	❄ 出生日期 DATE OF BIRTH

❄ 您有第二保险吗 DO YOU HAVE SECONDARY INSURANCE ☐ 是 YES ☐ 否 NO

第二保险公司名称 NAME OF SECONDARY INSURANCE

保险卡号 POLICY NUMBER GROUP NUMBER

主要受保人SUBSCRIBER OF SECONDARY INSURANCE ☐ 本人SELF ☐ 配偶 SPOUSE ☐ 父母 PARENT ☐ 其他 OTHER

主要受保人若非本人，请填写以下信息

❄ 姓 LAST NAME	❄ 名 FIRST NAME	❄ 出生日期 DATE OF BIRTH

医疗信息

家庭医生

❄ 姓 LAST NAME	❄ 名 FIRST NAME	电话 TELEPHONE

药房 PHARMACY	❄ 名称 NAME	❄ 街道地址 STREET ADDRESS
❄ 城市 CITY	❄ 邮编 ZIP	❄ 电话 TELEPHONE

❄ 药物过敏史 ALLERGIES TO MEDICATIONS

现用药物 CURRENT MEDICATIONS

要求附件

❄ ☐ 保险卡正反面相片

❄ ☐ 身份证明正反面相片， 例如驾照。

☐ 如果你的保险公司有要求，请你的家庭医生开电子转诊单

☐ 相关病历

病人签名 SIGNATURES AND CONSENTS

请详细阅读第二页内容， 同意请在以下三处空格内签名

I have read and understand the OFFICE POLICES on page 2 and agree to abide by its guidelines.

汉语拼音拼写全名	❄ 签名（可以打字）	❄ 日期 DATE

I have read and understand the AUTHORIZATION FOR HEALTH INSURANCE CLAIM on page 2 and agree to abide by its guidelines.

汉语拼音拼写全名	❄ 签名（可以打字）	❄ 日期 DATE

I have read and understand the HIPAA PATIENT CONSENT on page 2 and agree to abide by its guidelines.

汉语拼音拼写全名	❄ 签名（可以打字）	❄ 日期 DATE

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OFFICE POLICIES

Thank you for choosing New Jersey Digestive Disease Associates for your medical care. Please read the following information so that we may make your experience with our practice a positive and productive one. Below are a few office policies:

- **Release of medical information:** you authorize New Jersey Digestive Disease Associates (Bingru Xie Digestive Diseases Associates Medical PC) to release your medical records to any physicians, hospitals, or agency involved in your medical care.
- **Payment policy**: Co-payments are to be collected at the time services are received. We accept cash, checks and credit cards. All medical services provided are directly charged to the patient or responsible party. The patient will be responsible for any balance that is not covered by his/her insurance policy. Private pay and non-insured patients will be asked for payment at the time of service.
- **Referrals**: Please check with your insurance company and your primary care physician's office whether you need referrals to see a specialist. Failure to provide referral at time of visit may result in charges billed directly to yourself.
- **No Show and Cancellation Fee**: A 24-hour cancellation notice is required for all appointment's cancellation. We reserve the right to charge a fee for repeated no show appointments.
- **Medical Records**: Written authorization from the patient/parent or guardian must be obtained to release medical records. At least one week's notice is required to complete your request for medical records. The cost is $50 when records are released directly to the patient. There is no charge if records are forwarded directly to a new physician.
- Office policies subject to change without notice

AUTHORIZATION FOR HEALTH INSURANCE CLAIM

The patient, the signed, certify that he/she (or his/her dependent) has insurance coverage and assign directly to Bingru Xie Digestive Diseases Associates Medical PC all insurance benefits otherwise payable to the patient or dependent for services rendered. The patient understand he/she is ultimately responsible for all charges accumulated. The patient understand that he/she is financially responsible for any balance if his/her insurance is invalid. The patient hereby authorizes Bingru Xie Digestive Diseases Associates Medical PC to release all information necessary to secure the payments of benefits and authorize the use of this signature on all insurance submissions. A photocopy of this Authorization shall be considered as effective and valid as the original.
The patient requests that payment of authorized Medicare benefits be made either to him/her or on his/her behalf to Bingr u Xie Digestive Diseases Associates Medical PC for services furnished to him/her by the provider. The patient authorizes any holder of medical information about him/her to release to the centers for Medicare and medical services and its agents any information needed to determine these benefits payable for related service.

HIPAA PATIENT CONSENT

Our Notice of Privacy Practices Provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Right section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain *a* revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any discloses we have already made in reliance on your prior Consent. Bingru Xie Digestive Diseases Associates Medical PC provides this to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The Patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The practice has a Notice of Privacy Practices and that the patient could review this notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The Patient has the right to restrict the use of their information, but the practice does not have to agree to those restrictions.
- The patient may revoke this consent in writing at any time and all future disclosures will then cease.
- The practice may condition receipt of treatment upon the execution of this Consent