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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

PATIENT REGISTRATION FORM

❁ Required fields ❁ Signature

Note: you can send filled form and required attachments back to us by email (njddageneral@gmail.com), fax (732-362-4619), mail (247 Bridge Street, Building G, 08840) or in person.

❁ LAST NAME		❁ FIRST NAME		❁ DATE OF BIRTH	
❁ SEX	☐ MALE	☐ FEMALE	MARITAL STATUS	☐ SINGLE ☐ MARRIED	☐ OTHER

HOME (MAILING) ADDRESS

❁ STREET	❁ CITY	❁ STATE	❁ ZIP
❁ CELL PHONE	HOME PHONE	❁ EMAIL	

EMERGENCY CONTACT

RELATIONSHIP	LAST NAME	FIRST NAME	CELL PHONE

INSURANCE INFORMATION

❁ NAME OF PRIMARY INSURANCE				
❁ POLICY NUMBER	GROUP NUMBER			
❁ SUBSCRIBER OF PRIMARY INSURANCE	☐ SELF	☐ SPOUSE	☐ PARENT	☐ OTHER
SUBSCRIBER INFO (IF OTHER THAN YOURSELF)				
❁ LAST NAME	❁ FIRST NAME	❁ DATE OF BIRTH		
❁ DO YOU HAVE SECONDARY INSURANCE	☐ YES	☐ NO		
NAME OF SECONDARY INSURANCE				
POLICY NUMBER	GROUP NUMBER			
SUBSCRIBER OF SECONDARY INSURANCE	☐ SELF	☐ SPOUSE	☐ PARENT	☐ OTHER
SUBSCRIBER INFO (IF OTHER THAN YOURSELF)				
LAST NAME	FIRST NAME	DATE OF BIRTH		

MEDICAL INFORMATION

PRIMARY CARE PHYSICIAN/REFERAL PHYSICIAN			
❁ LAST NAME	❁ FIRST NAME	TELEPHONE	
PHARMACY	❁ NAME	❁ STREET ADDRESS	
❁ CITY	❁ ZIP	❁ TELEPHONE	
❁ ALLERGIES TO MEDICATIONS			
CURRENT MEDICATIONS			

ATTACHMENTS

- ❁ ☐ A copy of front and back pictures of your insurance cards
- ❁ ☐ A copy of front and back pictures of your official identification card, i.e. driver's license
- ☐ A copy of electronic referral from your primary care physician if required by your insurance
- ☐ Any related medical records

SIGNATURES AND CONSENTS

I have read and understand the OFFICE POLICES on page 2 and agree to abide by its guidelines.		
❁ PRINT NAME	❁ SIGNATURE (You can type)	❁ DATE
I have read and understand the AUTHORIZATION FOR HEALTH INSURANCE CLAIM on page 2 and agree to abide by its guidelines.		
❁ PRINT NAME	❁ SIGNATURE (You can type)	❁ DATE
I have read and understand the HIPAA PATIENT CONSENT on page 2 and agree to abide by its guidelines.		
❁ PRINT NAME	❁ SIGNATURE (You can type)	❁ 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 Bingru 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