Hunterdon Gastroenterology Associates
Medical Experts in the Treatment of Digestive Diseases

Hunterdon Doctors Office Building
1100 Wescott Drive Suites 205/206
Flemington, NJ 08822

T: 908-483-4000
F: 908-788-5090

Somerville Location
135 West End Avenue
Somerville, NJ 08876

TODAY'S DATE: _____

Patient History Form

First:_____Middle:_____ Last: _____DOB:_____
Maiden Name: _____ SS#: _____Occupation: _____
Place of Birth: _____ Marital Status: _____ Gender: □ Male □ Female □ Other
Street Address:_____City: _____ State: _____Zip: _____
Reason for today's visit: □ Bariatric Surgery
□ Other: _____
How did you hear about our practice? _____
Please complete below. Check box below for preferred call, email, or text for your office confirmation:

□Home:_____ □Cell:_____ □Work:_____

□Email:_____ □Other: _____

Preferred Lab: Quest _____Labcorp_____Other_____

Preferred Radiology: _____ _____
Name Location
Preferred Pharmacy: _____ _____
Name Location
Primary Care Physician:_____ _____
Name Phone #
Referring Physician:_____ _____
Name Phone #

Disclaimer: The United States Federal Government has established criteria for meaningful use of electronic medical records. Each provider needs to show that they are using the electronic medical record technology in a way that can be measured significantly in quantity and quality. We are therefore required to ask certain questions which pertain to your personal history and social behaviors. You as an individual have the option to decline to answer.

Please Check the Appropriate Box

Preferred Language: □ Declined to answer □ English □ Spanish □ Other: _____

Race: □ Decline to answer □ Black/African American □ Hispanic/Latino □ Asian □Unknown □White

Ethnicity: □ Decline to answer □ Hispanic/Latino □ Not Hispanic/Latino □Unknown /not reported

Do you have an Advanced Directive: □ Yes □No □ Decline to answer

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Documentation of receipt of Notice of Privacy Practices
Effective September 23, 2013

Medical Information Consent

Hunterdon Gastroenterology Associates reserve the right to modify the privacy practices outlined in this notice.
Upon request, you may obtain a paper copy of this Notice.

_____Yes, I have received a copy of the Notice of Privacy Practices for Hunterdon Gastroenterology Associates.

_____ No, at this time I have declined a copy of the Notice of Privacy Practices for Hunterdon Gastroenterology Associates and understand that at anytime I can request a written copy of this Notice.

_____ _____
Print Name Date of Birth

_____ _____
Patient Signature Today's Date

_____ _____
Signature of Parent or Legal Guardian Today's Date
(If patient is under the age of 18 or POA)

HIPAA Disclosure Information

Should I not be available, I give Hunterdon Gastroenterology Associates permission to release my medical information to the following person(s):

_____ Any health care provider or facility. (please list physician or facility).
_____
_____
_____ Family (please provide names)
_____Parent _____
_____Spouse _____
_____Child _____
_____Sibling _____
_____Other _____
_____ I choose to receive voice messages on the telephone or answering machine.
_____ I choose not to have my medical information released to anyone but myself.

_____
Print Name

_____ _____
Patient Signature Today's Date

_____ _____
Signature of Parent or Legal Guardian Today's Date
(If patient is under the age of 18 or POA)

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Patient Payment Responsibility and Authorization

Insurance plans today have large variations depending on the employer who contracted with the insurer. We are in-network providers for many plans, therefore, it is difficult for our office to know the details and restrictions of your policy. Ultimately, you the patient are responsible for any services we provide to you.

It is essential that you the patient know the services covered by your insurance plan. For example, some policies reimburse for annual preventive examinations, and others do not. Referral requirements vary from plan to plan. You the patient will be responsible for any non-covered services provided. We will bill you and expect payment from you for these services.

By signing below you the patient agree to assume responsibility for payment of non-covered services and also deductibles, co-payments and co-insurances that are part of your policy. If your account is delinquent and sent to a collection agency, a collection fee of $50.00 or 20% whichever is greater, will be added to your unpaid balance.

I hereby authorize Dr. Kenneth J. DiGregorio, Dr. Samuel Y. Bae, Dr. Gilbert S. Cardoso, Dr. Jason D. Matthews, Dr. Andrea E. Goldstein, Dr. Maria A. Georgsson, Dr. Cherag Daruwala, Dr. Anik Patel, Dr. Richard Arrigo or Allison Hood PA-C to furnish information to my insurance carrier concerning my illness and treatment including health care financing administration and its agents if I am a Medicare holder.

I request that payment of authorized insurance payments be made on my behalf to either Dr. Kenneth J. DiGregorio, Dr. Samuel Y. Bae, Dr. Gilbert S. Cardoso, Dr. Jason D. Matthews, Dr. Andrea E. Goldstein, Dr. Maria A. Georgsson, Dr. Cherag Daruwala, Dr. Anik Patel, Dr. Richard Arrigo, or Allison Hood PA-C for all charges whether or not paid by my insurance.

This authorization will be retained in my file. This authorization may be revoked either by me or my insurance company at any time in writing.

_____ _____

Patient Name Date of Birth

_____ _____

Patient Signature Date

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Patients Responsibilities for Follow Up Care Pledge

I, _____(Print name), hereby acknowledge and understand that even with the best training, skill and experience, a medically trained professional is not always capable of solving my medical problems. Therefore, I understand it is important that any and all recommendations by doctors are followed completely in order to increase the likelihood of a positive and healthy treatment/outcome. I acknowledge and understand that if any physician in this office prescribes medicine to me that the proper taking of any such medicine shall be my sole responsibility (or my guardian who has attended this consultation). I agree to properly follow the prescribed dosage and frequency amounts of these medicines as recommended by my doctor.

I understand that if a doctor in this office refers me to see another doctor or receive another test including, but not limited to, a blood test, and MRI, or CT scan, this timely recommendation is important and essential to the ultimate success of my treatment/outcome. I understand that it is not possible for any person in this office to constantly follow-up to ensure that I have followed these recommendations. Therefore, I understand that if I fail to see that specialist or obtain the test for which I was referred immediately, this can risk my current health or increase future health risks.

I understand that it is solely my responsibility to follow any of the medical advice given by any medical person in this office and any bad health outcome from my failure to follow the advice of my doctors should be expected.

_____ _____
Patient Name Date of Birth

_____ _____
Patient Signature Date

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Nextgen Unified Chart Opt In Status

I hereby choose to participate in the Nextgen Unified Electronic Medical Record. I understand that the information contained in my Electronic Medical Record WILL BE SHARED electronically with other providers and affiliates that are involved in my care at Hunterdon Healthcare. I also understand that information contained in my Electronic Medical Record will be available to the Hunterdon Medical Center Emergency Department in the event of an emergency.

I also understand that by disclosing my email address in my Electronic Medical Record I am authorizing consent to receive and send HIPAA Compliant emails through Hunterdon Healthcare's Nextgen Patient Portal. These emails will be sent and received by the providers and affiliates involved in my care at Hunterdon Healthcare.

I was also given a letter from the practice explaining what Unified Chart and Patient Portal is and have been given the opportunity to ask questions at this time. I also understand that I will be given the opportunity to discuss my option to Opt In or Opt Out of Unified Chart with my physician.

Today's Date: _____Date of Birth: _____

Patient Name or Guardian Name (Please Print):

_____

Patient or Guardian Signature:

_____

Staff Initials: _____