



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: _____ [] Text: _____ [] 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

HIPAA Disclosure Information

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
(If patient is under the age of 18 or POA)

Today's Date

Medical Information Consent

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

Patient or Responsible Party: Please acknowledge your consent and understanding of the following terms regarding patient care at Hunterdon Gastroenterology Associates and Hunterdon Endosurgery Center (herein known as HGA/HEC) by initialing and signing where indicated. Please contact our billing department with any questions.

Terms and Policies	Initials
Authorizing the Release of Information: I authorize HGA/HEC to release any necessary medical records to the appropriate parties (insurance, pharmaceutical companies, etc.) in relation to determining responsibility for medical benefits and obtaining reimbursement for professional services.	
Professional Fees: I understand that I am financially responsible for any and all charges for professional services, whether or not paid by an insurance carrier or health plan. Exceptions are when patient financial responsibility is limited by statutory regulation such as Medicare or by managed care (HMO, PPO, etc.) contract. In cases submitted to my insurance carrier, it is my responsibility to financially cover any deductibles, co-payments, and non-covered services as stipulated by my specific insurance plan. I may request that payment of my authorized benefit be made on my behalf and assigned to HGA/HEC. Any payment/explanation of benefits issued directly to me for care received at HGA/HEC must be forwarded to HGA/HEC in a timely fashion for posting of payment and/or appropriate adjustment.	
Managed Care: To validate your managed care agreement/fee schedule, proof of your insurance coverage and personal identification must be provided at the time of service, along with necessary authorizations/referrals. All associated co-payments and deductibles will be collected at the time of visit. Without proper documents, you may be required to pay in full.	
Referrals: If my insurance plan requires a referral, it is my responsibility to obtain and present the referral at the time of service. If one is not obtained, I may be responsible for payment in full.	
Collection Agency: If my account is over 90 days past due, a letter will be sent stating that I have 20 days to pay the account in full. Partial payments will no longer be accepted unless negotiated by the billing department. If the balance continues to remain delinquent, I may be sent to a collection agency where a collection fee of \$50.00 or 20% (whichever is greater) will be added to the unpaid balance. The practice may also discharge me from the practice for non-payment.	
Forms: Requests for completion of disability forms, reports, or other paperwork will require an advance fee based on the complexity of the form. Please allow 5 business days for completion.	
Release of Medical Records: Medical records copies require written authorization and prepaid fees related to preparation. Please allow 10 days for copies.	
Missed Appointment/Procedure: I acknowledge that I am responsible for any missed appointments or any cancelled appointments in which a 24 hour notice was not given. The fee for a missed office appointment in HGA is \$30.00. HEC requires 48 hour notice of cancelling a procedure and the fee for a missed procedure is \$250.00 for each procedure.	
Returned check fee: I understand that there will be a \$25.00 fee for all returned checks.	
Divorced Parents of Minor Patients: The adult who signs a minor patient into our practice on the day of service accepts responsibility of payment or communication. It is the responsibility of both parents to communicate with each other about payment issues.	
Patient balance credits of \$15.00 or less will be kept on file for future use unless requested by patient.	

Printed name of the patient

Patient Date of Birth

Signature of the Patient or Guardian

Date

Printed name of the Guardian



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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: _____