JERSEY SHORE
GASTROENTEROLOGY

M. KRACHMAN • K. SCHWAB • P. LJUBICH • L. OGNIBENE • N. DESHPANDE • S. JALAJ • D. D'AURIA • M. DIENER

Dear: _____ Your appointment is on: _____ / _____ / _____ at: ____ : ____ AM | PM

YOU ARE SCHEDULED WITH THE FOLLOWING PHYSICIAN/OFFICE:

- ☐ Michael Krachman, M.D.
- ☐ Kenneth Schwab, M.D.
- ☐ Paul Ljubich, M.D.
- ☐ Lawrence Ognibene, D.O.
- ☐ Nikhil Deshpande, M.D.
- ☐ Sujai Jalaj, M.D.
- ☐ Daniel D'Auria, M.D.
- ☐ Melissa Diener, M.D.

- ☐ 408 Bethel Road
  Point Commons – Suite E
  Somers Point, NJ 08244
- ☐ 425 Route 9 North
  Cape May Court House, NJ 08210
- ☐ 517 Route 72 West
  Manahawkin, NJ 08050
- ☐ 2500 English Creek Avenue
  Building 900, Suite 903
  Egg Harbor Township, NJ 08234
- ☐ 219 N. White Horse Pike, Suite 104
  Hammonton, NJ 08037
- ☐ 1133 East Chestnut Avenue, Building 2,
  Suite A, Vineland, NJ 08360

To reach us please call:

Somers Point: 609-926-3330 (Fax: 609-926-8578)

Egg Harbor Township: 609-645-1880 (Fax: 609-645-1277)

Cape May Court House: 609-465-0060 (Fax: 609-465-0187)

Vineland: 856-839-2128 (Fax: 856-839-2118)

Manahawkin and Hammonton can be reached through our Somers Point office

Please complete and bring the attached forms to your appointment, along with:

- ☐ INSURANCE CARD(S)
- ☐ REFERRAL /CO-PAY (if either are required - please call your insurance company if unsure)
- ☐ CURRENT MEDICATIONS
- ☐ ANY GASTROINTESTINAL RELATED TESTS AND/OR LABWORK.
- ☐ An EKG (if done within 6 months of the visit)

We look forward to seeing you at your appointment

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PATIENT INFORMATION

Name: _____

Street Address: _____

_____

City: _____

State: _____ Zip: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Email Address: _____

Sex: ☐ Male ☐ Female

Birth Date: _____ / _____ / _____

SS#: _____ – _____ – _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Race: ☐ Asian ☐ American Indian or Alaska Native

☐ Black or African American ☐ Hispanic

☐ Native Hawaiian or Other Pacific Islander ☐ White

Language: ☐ English ☐ Spanish ☐ Other

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

EMPLOYMENT INFORMATION

Employer Name: _____

Street Address: _____

_____

City: _____

State: _____ Zip: _____

PHYSICIAN INFORMATION

Referring Doctor: _____

Primary Doctor: _____

EMERGENCY INFORMATION

Contact Person: _____

Relationship: _____

Home Phone: _____

Cell Phone: _____

Street Address: _____

_____

City: _____

State: _____ Zip: _____

PRIMARY INSURANCE INFORMATION

Insurance Name: _____

Insurance ID #: _____

Group #: _____

Referral Required: ☐ Yes ☐ No

Co Pay Amount $: _____

Subscriber Name: _____

Patient's Relationship to Subscriber: _____

Subscriber's Birth Date: _____ / _____ / _____

Subscriber's SS#: _____ – _____ – _____

Subscriber's Employer: _____

SECONDARY INSURANCE INFORMATION

Insurance Name: _____

Insurance ID #: _____

Group #: _____

Referral Required: ☐ Yes ☐ No

Co Pay Amount $: _____

Subscriber Name: _____

Patient Relation to Subscriber: _____

Subscriber's Birth Date: _____ / _____ / _____

Subscriber's SS#: _____ – _____ – _____

Subscriber's Employer: _____

Pharmacy Name: _____

Address: _____

_____

Phone: _____

ASSIGNMENT OF BENEFITS/MEDICAL INFORMATION RELEASE

I request that payment of authorized Medicare and other Insurance carriers benefits be made on my behalf to Jersey Shore Gastroenterology Associates for any services furnished me by physician or supplier.
I authorize any holder of medical information about me to release to the Health Care Financing Administration and other insurance companies and its (their) agents any information needed to determine these benefits or the benefits payable for related services.

_____ ____ / ____ / ____

Patient's or Guardian's Signature Date

Name: _____ Birth Date: _____ / _____ / _____

MEDICAL HISTORY (Check all that apply):

- ☐ Cardiac disease
- ☐ Asthma / Lung disease
- ☐ Diabetes
- ☐ Kidney disease
- ☐ Thyroid disease
- ☐ Cancer
- ☐ Seizure disorder
- ☐ Bleeding disorder
- ☐ Anemia
- ☐ Hepatitis / Liver disease
- ☐ Ulcers / Acid reflux
- ☐ Crohn's disease
- ☐ Stroke

Please list any other medical problems that you have: _____

SURGICAL HISTORY (Please list ALL surgeries that you have had): _____

FAMILY HISTORY (e.g. colon/stomach cancer, Crohn's disease, colitis, ulcers, gallbladder disease.): _____

SOCIAL HISTORY

Occupation: _____

Are you: ☐ SMOKER ☐ NON-SMOKER ☐ FORMER-SMOKER

Do you drink alcohol? **YES | NO** If so, how much? _____

Do you use recreational drugs? **YES | NO** Is there a history of drug use? **YES | NO** Do you have tattoos? **YES | NO**

ALL CURRENT MEDICATIONS (Please use enclosed "Medications" form if more space is needed): _____

Are you allergic to any medication or Latex? **YES | NO**

WHAT IS THE REASON FOR YOUR VISIT TODAY?: _____

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OFFICE POLICIES

CANCELLATION POLICY

As all of our patients are valuable to us, so is our time with them. We ask that appointments be cancelled at least 24 hours prior to the appointment in order to allow other patients to utilize this time. If this policy is not honored, a $20 cancellation fee may be added to your account (your insurance will not cover this fee). After 3 missed appointments, you may no longer be treated in our office.

REFERRALS

It is your responsibility to obtain a referral if required by your insurance AND it is due at the time of service. If you do not have your referral, we will reschedule your appointment. This is a requirement of YOUR insurance company.

CO-PAY

If a co-pay is required by your insurance, it is due at the time of service. Please note, we accept cash, credit cards or checks.
There is a $20.00 charge for returned checks.

STATEMENTS

Unpaid balances will be assessed a $10 billing surcharge on the third statement. If your account is turned over to collections, 25% plus interest will be added to your balance to cover legal and collection fees.

PROCEDURES

It is your responsibility to verify your insurance rules and regulations regarding procedures. Jersey Shore Gastroenterology has no control over what your insurance will or will not allow. Jersey Shore Gastroenterology is not responsible for any charges for doctors, facilities, anesthesia, lab or pathology not covered by your insurance. We recommend contacting your insurance for clarification on your insurance coverage.

_____ _____ ____ / ____ /____

Patient's or Guardian's Signature | Print Name | Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (NPP):

My signature below acknowledges that I have received or have been offered a copy of Jersey Shore Gastroenterology's (JSG's) Notice of Privacy Practices, and I am aware that I have access to this document on their website at www.jerseyshoregastro.com

Patient or Authorized Representative Signature _____ Date _____

OR

In an emergency treatment situation, obtain the NPP acknowledgement as soon as it is reasonably practicable to do so after the emergency situation has ended.

The Patient is unable to sign because (check one)

☐ Patient is critical or unconscious

☐ Patient refuses to sign

☐ Communication barriers prohibited obtaining the acknowledgement

CERTIFICATION OF GOOD FAITH EFFORTS TO OBTAIN ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES (NPP):

I hereby certify that as an associate or agent of JSG, I have made a good faith effort to obtain from the patient or the patient's authorized representative a written acknowledgment of the JSG's NPP in accordance with its Provision of Notice of Privacy Practices

JSG Representative Name_____

Position_____ Date _____

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Michael Krachman, M.D., F.A.C.P.
Kenneth Schwab, M.D., F.A.C.P.
Paul Ljubich, M.D., F.A.C.P., C.N.S.P.
Lawrence Ognibene, D.O., F.A.C.O.I.
Nikhil Deshpande, M.D., F.A.C.P.
Sujai Jalaj, M.D.
Daniel D'Auria, M.D.
Melissa Diener, M.D.

SOMERS POINT OFFICE
PHONE: (609) 926-3330 FAX: (609) 926-8578

EGG HARBOR TWP OFFICE
PHONE: (609) 645-1880 FAX: (609) 645-1277

CAPE MAY COURT HOUSE OFFICE
PHONE: (609) 465-0060 FAX: (609) 465-0187

VINELAND OFFICE
PHONE: (856) 839-2128 FAX: (856) 839-2118

INFORMED AUTHORIZATION CONSENT FOR THE RELEASE OF MEDICAL RECORDS

I hereby authorize Jersey Shore Gastroenterology Associates, P.A. to obtain/release the medical records of:

Name: _____ Birth Date: _____ / _____ / _____

☐ **RELEASE TO:**

_____

_____

_____

_____

_____

☐ **OBTAIN FROM:**

_____

_____

_____

_____

_____

Records to be released: _____

_____

_____

_____

_____ _____ ____ / ____ /____

Patient's or Guardian's Signature Print Name Date

HIPAA NOTICE OF PRIVACY PRACTICES (NPP) FORM

This is a Notice of Privacy Practices. It describes how medical information about you may be used and disclosed and how you can get access to this information. Review this carefully. You will be asked to acknowledge that you have received a copy of our Notice of Privacy Practices.

We understand that information about you and your health is very personal. We strive to protect your privacy. We will only use or disclose your personal health information as allowed by law.

Your personal health information will be used to provide you care, and where applicable to educate other healthcare professionals and for research. We train our staff to respect privacy and protect the confidentiality of your personal health information. We are required by law to maintain the privacy of our patients' personal health information and to provide you with notice of our legal obligations and privacy practices. We are further required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of this Notice as necessary.

You may receive a copy of this Notice or any revised Notice at any time at any of our JSG locations or a copy may be requested in writing to **JSG HIPAA Compliance;** 408 Bethel Road, Suite E, Somers Point, NJ 08244.

USES AND DISCLOSURE

The following categories detail the various ways in which we may use or disclose your personal health information. Your records will be maintained by us for approximately seven years after your last appointment. After that time has elapsed, your records will be shredded to protect your privacy.

Your Authorization: Except as outlined below, we will not use or disclose your personal health information for any purpose unless you have signed an authorization allowing us to do so. You have the right to revoke the authorization at any time in writing.

Uses and Disclosures for Treatment: We will use and disclose your personal health information as necessary for your treatment. For instance, to remind you about appointments or visits, or doctors, nurses and other professionals involved in your care will use information in your medical record and information you provide to plan a course of treatment for you that may include procedures, medications, tests, etc. We may also disclose your personal health information to institutions or individuals outside of our Practice that are or will be providing services or care to you.

Uses and Disclosures for Payment: We will use and disclose your personal health information as necessary for payment purposes. For instance, we may forward information regarding your medical procedures and treatment to your insurance company to arrange payment for the services provided to you or we may use information to prepare a bill to send to you or the person responsible for your payment.

Uses and Disclosures for Healthcare Operations: We will use and disclose your personal health information as necessary for healthcare operations. This is necessary to run our Practice and ensure that our patients receive high quality care. For example, we may share your personal health information in order to conduct an evaluation of the treatment or services provided or to educate or review the performance of our staff.

Persons Involved in Your Care: Unless you object, we may disclose personal health information to members of your family or a close friend or any other person you identify, to facilitate that person's involvement in your care or payment, or to assist a family member, personal representative or other person responsible for your care of your location and general condition.

Health Products and Services: We may use personal health information to communicate with you about treatment alternatives or other health related benefits or services that may be of interest to you.

Research: We may use and disclose your information for research. In these cases your privacy will be protected by the confidentiality of the research.

Business Associates: Certain aspects and components of our services are performed through contracts with outside persons or organizations. It may be necessary for us to share your personal health information with these outside organizations who assist us with treatment, payment or operations. In such cases we require these business associates to properly safeguard the privacy of your personal health information.

Other Uses and Disclosures: We are permitted or required by law to make certain other uses or disclosures of your personal health information without your consent or authorization. Subject to conditions specified by law. We may release your personal health information for any purpose required by law;

- We may release your personal health information for public health activities such as required reporting of diseases, birth and death and for required public health investigations;
- We may release your personal health information to certain governmental agencies if we suspect child abuse or neglect. We may also release your personal health information to certain governmental agencies if we believe you to be a victim of abuse, neglect or domestic violence;
- We may release your personal health information to entities regulated by the Food and Drug Administration if necessary to report adverse event product defects, or to participate in product recalls;
- We may release your personal health information to your employer when we have provided health care to you at the request of your employer for purposes related to occupational health and safety; in most cases you will receive notice that the information is disclosed to your employer;

- We may release your personal health information if required by law to a government oversight agency conducting audits, investigations, inspections and related oversight functions;
- We may use or disclose your personal health information in emergency circumstances such as to prevent a serious and imminent threat to a person or the public;
- We may release your personal health information if required to do so by a court or administrative order or subpoena or discovery request; in most cases you will have notice of such release.
- We may release your personal health information to law enforcement officials to identify or locate suspects, fugitives or witnesses or victims of crime or for other allowable law enforcement purposes;
- We may release your personal health information to coroners, medical examiners and/or funeral directors;
- We may release your personal health information to arrange an organ or tissue donation from you or a transplant for you;
- We may release your personal health information if you are a member of the military for activities set out by certain military command authorities as required by armed forces services or for national security, intelligence or protective services activities; and
- We may release your personal health information if necessary for purposes related to your workers' compensation benefits.

The confidentiality of alcohol and drug abuse patient records, HIV-related information and mental health records maintained by us is specifically protected by state and/or Federal law and regulations. Generally we may not disclose this information unless you consent in writing, the disclosure is allowed by a court order or in limited and regulated other circumstances

RIGHTS THAT YOU HAVE

Access to Your Personal Health Information: Generally you have the right to access, inspect, and/or copy personal health information that we maintain about you. Unless it is during a scheduled appointment with a clinician, the request for access must he made in writing and be signed by you or your representative. We will charge you for a copy of your medical records in accordance with a schedule of fees established by applicable state law. You may obtain a request form from the Medical Records department.

Amendments to Personal Health Information: You have the right to request that personal health information that we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. All requests must be in writing, signed by you or your representative and must state the reason for the amendment/ correction. If an amendment or correction you request is made by us we may also notify others who work with us and have copies of the uncorrected record, if we believe such notification is necessary. Please note that even if we accept your request we will not delete information already documented in your medical record. You may obtain an amendment request form from the Medical Records department.

Accounting of Disclosures: You have the right to receive an accounting or certain disclosures made by us of your personal health information after April 14, 2003 except for disclosure made for purposes of treatment. Payment and health care operations or for certain other limited exceptions. Requests must be made in writing. A fee may be charged.

Restrictions on Use and Disclosure: You have the right to request restrictions on certain uses and disclosures of your personal health information for treatment, payment and health care operations. For example, you may request that we do not share your health information with a family member, A restriction request form can be obtained from the medical records department. We are not required to agree to your restriction request but will attempt to accommodate reasonable requests when appropriate and we retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. We will notify you of this termination.

Confidential Communications: You have the right to request communications regarding your personal health information from us by alternative means or at alternative locations and we will accommodate reasonable requests. You must request such confidential communication in writing.

Paper Copy of Notice. As a patient you retain the right to obtain a paper copy of this Notice of Privacy Practices, even if you have requested such copy by e-mail or other electronic mail. Our Notice may also be obtained on our website at www.jerseyshoregastro.com.

ADDITIONAL INFORMATION

Complaints: If you believe your privacy rights have been violated, you may file a complaint in writing with our office or the HIPAA compliance office. You may also file a complaint with the Secretary of the US Department of Health and Human Services in Washington D.C. All complaints must be made in writing and in no way will affect the quality of care you receive from us.

For more information: If you have questions or need further assistance regarding this Notice of Privacy Practices, you may contact us in writing at **JSG HIPAA Compliance; 408 Bethel Road, Suite E, Somers Point, NJ 08244**