

**Mid State Gastroenterology, LLC**  
**901 West Main Street**  
**Medical Arts Bldg., Suite 107**  
**Freehold, NJ 07728**  
**Phone: 732-303-3888 Fax: 732-414-2292**

**Please Complete the Entire Form:**

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_ Middle Name \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ **Home #**

\_\_\_\_\_ **Cell:** \_\_\_\_\_

**Contact Preference:**

Home Phone:  Yes  No      Cell phone:  Yes  No      Work phone:  Yes  No      Consent to Call:  Yes  No

**Social Security #:** \_\_\_\_\_

Birth date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  M  F

Status:  Single  Married  Divorced  Widowed  Separated  Partner

Email Address: \_\_\_\_\_

(by declining email information for patient portal, you are also declining patient summary)

Occupation: \_\_\_\_\_ Work: \_\_\_\_\_

Employer Name/Address: \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone#: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone # \_\_\_\_\_

Office Location: \_\_\_\_\_

---

**Primary Insurance Information:**

Co-Pay Amount \$ \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_

ID: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber's (Policy Holder) Name: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

SS#: \_\_\_\_\_ Subscriber's Date of Birth: \_\_\_\_\_

---

**Secondary Insurance Information:** If Applicable

Co-Pay Amount \$ \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_



the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services. We agree to provide patients with access to their records in accordance with state and federal laws. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request. A full copy of the HIPAA policy is available upon request.

**For Medicare Assignment of Benefits**, I request that payment of authorized Medicare benefits be made either to me or on my behalf to Mid State Gastroenterology, LLC for any services furnished me by Mid State Gastroenterology, LLC. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

**For all other Insurance Assignment of Benefits**, I hereby authorize and instruct any and all insurance companies involved with my healthcare coverage to make payment directly to Mid State Gastroenterology, LLC. This is for the Professional Medical Expense benefits allowable and otherwise payable to me under my current insurance policy as payment towards the total charges for professional services rendered. This payment shall not exceed my indebtedness to the above practice, and I have agreed to pay any balance if said professional service charges are over and above this insurance portion of payment. A photocopy of this Assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to my Insurance Company or adjuster involved in the case, unless I have made alternative arrangements with respect to this data.

I understand that I am financially responsible for all charges whether or not paid by said insurances including copays, deductibles, coinsurance and non-covered charges. I authorize and give consent for my provider to bill me directly for recommended services performed that are not covered under the terms of my health plan. I authorize the physician to release any medical information required to process this claim. I authorize my provider's office to contact me by telephone to remind me of my appointments.

Statements are mailed out monthly by first class mail. We trust that all mailed statements are received by our patients. Therefore, if payment in full is not received on your account within 30 days, then the past due account may be reviewed for possible transfer to a collection agency. I also understand that any unpaid balances transferred to a collection agency or attorney are subject to an additional administration charge of Seventy-five Dollars (\$75) or 25% of the balance owed, whichever is greater, and are my responsibility. These fee may change at any time without prior notice.

**I have received the notice of Assignment of Benefits, Privacy Practices and Financial Policies statements and I have been provided the opportunity to review them. I hereby consent and acknowledge my agreement to the terms set forth in the HIPAA information form and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.**

**\*Patient's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Print Patient Name:** \_\_\_\_\_