Digestive Disease Center of New Jersey, LLC

Welcome

The staff at Digestive Disease Center of NJ would like to welcome you to our practice, and let you know a little about our office policy. If you would just take a moment and read the signs posted in our waiting room.

We at the office would like to make your experience with us very pleasant. As you know, when you called or went online for your first appointment, we took all of your insurance information so we could verify all information and let you know what you may need when you arrive, such as a referral, so you would have it on the day of your appointment. As a courtesy, in case you had forgotten the referral we would then call your Primary Care Doctor or go on the internet and retrieve it.

Now you must understand if we were unsuccessful in retrieving your referral and you choose to still be seen, then you will be responsible for that visit. It is also your responsibility to know when you need a new referral ex: if it expires or the amounts of visits are used up. We also need two forms of identification (your insurance cards and a photo id such as a drivers license) to avoid insurance fraud.

There are many insurance that we do participate in but there are also some insurance that we do not participate with. If you have an insurance that we are not in network with ex: any Medicaid plans and you still want to be seen, you will be responsible for the cost of the visit.

Another one of our signs states that copays are due at the time of the appointment. This is part of your contract with your insurance. We also contract with your insurance and we are obligated by contract to collect at the time of the service or we are now in violation of the contract. So if we need to bill for the copay we will now charge a $25.00 billing fee.

Our appointments are often scheduled months in advance, because of this we have established a waiting list of patients who want to be seen sooner. So please if you cannot make your appointment, please call us to reschedule, so in turn we may call these patients waiting and offer your appointment. We require at least 24 hour notice that you need to cancel your appointment or there will be a $50.00 cancellation/ no show fee. Also with any procedure scheduled we require 48 hour notice or there is a $100.00 fee. We do understand that sometimes unexpected things may occur and we will take that into consideration. We find by applying this office policy many more patients can be seen and very few have to wait a long length of time.

Most importantly we are here to service you. If there is anything we can do to help, or any questions you need answered, please at anytime ask us. We ask that you sign below and date that you understand our policy.

Sincerely,
Digestive Disease Center Management

Signature:_____ Date:_____

Advance Beneficiary Notice (ABN) and Financial Notification

PLEASE READ THIS ENTIRE NOTICE CAREFULLY, AND ASK US TO EXPLAIN IF YOU DO NOT UNDERSTAND ANY PART OF THIS.

BY SIGNING BELOW, YOU ARE VERIFYING THAT YOU HAVE READ AND UNDERSTAND THIS NOTICE, AND THAT YOU UNDERSTAND THAT YOU AS THE PATIENT ARE FINANCIALLY RESPONSIBLE FOR ANY OR ALL UNCOVERED SERVICES.

WHAT ARE UNCOVERED SERICES?

All insurance companies have rules that determine which medical services will be covered by an individual plan. As a service to our patients, we participate in most plans. However, this creates a problem, as there are now close to 300 different insurance plans for which we regularly see patients. Even an individual insurance company such as Aetna, Blue Cross etc. may have multiple different plans, each with different coverage. Although we attempt to precertify and verify insurance coverage before a service is provided, clearly this is difficult. In addition, even verification of coverage and pre-approval by your insurance company, DOES NOT

GUARANTEE that the insurance company will pay for the services. Many times, insurance companies determine that a service is not covered in retrospect, even though it may have been precertified and/or verified. Just because your insurance does not cover a particular service, does not mean that you should not have it, nor does it mean you do not need it medically. In many instances, we may know in advance if you are having a "non-covered service", and could give you an estimated cost, so that you have the opportunity to decide if you would like to proceed, and pay for the service yourself.

At times, however, despite our best efforts, we may not find out a service is uncovered until your insurance company declines to pay our claim.

In this instance, the bill becomes YOUR RESPONSIBILITY.

Please remember that your insurance coverage is a matter between you and your insurance company. Although we will assist you in any reasonable way possible to get reimbursed from your company, it may not be possible under the rules of your coverage.

Examples of uncovered services: Although a screening colonoscopy has been proven effective in preventing colon cancer, and has been approved by Medicare and many other companies, there are still companies that consider this as "uncovered". In addition, Medicare will not pay for a screening colonoscopy if you have had a screening colonoscopy within the past 10 years. Furthermore, even if the screening colonoscopy is covered, the new patient office visit for screening may not be. You can see how this can get complicated.

Therefore, the purpose of this form is to help you understand, and to make an informed choice about whether or not you want to receive an "uncovered service". In addition, we hope you will understand the possibility that at times a service will be deemed as "uncovered" in retrospect. In either of these instances, the failure of your insurance company to pay for an "uncovered service" does not relieve you of the responsibility to pay for it.

I have read and understand this ABN and my financial responsibility for uncovered services:

Patient or Legal Representative_____Date_____

CONFIDENTIALITY

The Digestive Disease Center of New Jersey takes all necessary precautions to assure patient confidentiality, and to abide by FEDERAL GUIDELINES. Therefore, any record requests must be in writing, and signed by the patient or his/her legal representative. Information can no longer be given to family members by telephone, and can no longer be faxed, unless being sent directly to a physician's office. Therefore, records can be sent directly to another treating physician at no charge. There will be a reasonable charge for copying and sending records for your personal or non-medical use, and in such a situation, records must be sent to you directly, your legal representative directly, or can be picked up in person. When picking up records in person, we request that in order to release your records to someone other than yourself or legal representative that you provide a written, signed and dated release for the person who is to take your records. Charges will include postage if applicable, and will be payable in advance, or at the time of pickup of records.

Patient or Legal Repersentative_____Date_____

AUTHORIZATION FOR ASSIGNMENT AND RELEASE

I hereby authorize that any insurance benefits be paid directly to the listed physicians:
Dr. M. Ferges, Dr. Rapisarda, Dr. Merkel, Dr. Aronson, and Dr. W. Ferges
Tax ID# 22-3380090
33 Clyde Road Suite 102
Somerset, NJ 08873

The Digestive Disease Center of New Jersey will submit all claims with the insurance information I provided, and will do so in a timely manner, in accordance with my insurance company's filing policy also authorize the above-named physicians to release any information required in the processing of these claims.

Patient or Legal Representative_____Date_____

HIPPA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIDES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS CAREFULLY.

This Notice Of Privacy Practices describes how we my use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (tpo) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

USE AND DISCLOSURES OF PROTECTED HEALTH INFORMATION
Your protected health information may be used and disclosed by your physician, our office staff and others outside of your office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.
TREATMENT: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred too to insure that the physician has the necessary information to diagnose or treat you.
PAYMENT: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.
HEALTH CARE OPERATIONS: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but not limited to, quality assessment activities, employee review activities, training of medical students, licensing and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

This notice was published and became effective on/or before April 14, 2003

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with HIPPA COMPLIANCE OFFICER in person or by phone at our main phone number. Signature below is only acknowledgment that you have received this NOTICE OF OUR PRIVACY PRACTICES.

PRINT NAME: _____SIGNATURE:_____
DATE: _____

A "good faith effort" was made to get a signature from the patient, guardian or caretaker. It was not obtained because:

The patient, guardian, or caretaker refused to sign_____or other (specify)

_____

_____

I give my permission to Digestive Disease Center of New Jersey to speak with:

_____

_____

_____

With regards to my medical situation.

PRINT NAME: _____SIGNATURE:_____

DATE: _____