



Atlantic Coast Gastroenterology Associates L.L.C.

1640 Route 88 W
Suite 202
Brick, NJ, 08724

1944 Corlies Avenues
Suite 205
Neptune, NJ, 07753

ATTENTION PATIENTS

PLEASE BE ADVISED THAT OUR OFFICE DOES SUBMIT YOUR ENCOUNTER VISIT WITH THE PHYSICIAN TO YOUR INSURANCE COMPANY. WE RELY ON OUR PATIENTS TO SUPPLY US WITH THE CORRECT INSURANCE INFORMATION.

DUE TO DIFFICULTIES BEYOND OUR CONTROL WE MUST MAKE OUR PATIENTS AWARE THAT IF YOU SUPPLY OUR OFFICE WITH THE WRONG INSURANCE INFORMATION AT THE TIME OF SERVICE AND THEN YOU FURNISH OUR OFFICE WITH THE CORRECT INSURANCE AT A LATER DATE AND THE CLAIM IS DENIED DUE TO TIMELY FILING. YOU MAY BE RESPONSIBLE FOR YOUR BALANCE IN FULL.

IT IS YOUR RESPONSIBILITY TO SUPPLY OUR OFFICE WITH ALL CORRECT INFORMATION AT THE TIME OF SERVICE. PLEASE VERIFY WITH THE RECEPTIONIST THAT WE HAVE ALL OF YOUR INSURANCE INFORMATION CORRECT.

I HAVE READ THE ABOVE NOTICE AND I AM AWARE THAT IF I DO NOT SUPPLY THIS OFFICE WITH MY CORRECT BILLING INFORMATION I MAY BE RESPONSIBLE FOR MY BALANCE IN FULL.

PATIENT SIGNATURE

DATE



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PATIENT RECORD OF DISCLOSURES

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (CHECK ALL THAT APPLY)

HOME TELEPHONE _____

CELL PHONE _____

___ OK TO LEAVE A MESSAGE WITH DETAILED INFORMATION

___ LEAVE MESSAGE WITH A CALL BACK NUMBER ONLY (NO INFORMATION)

WORK TELEPHONE _____

___ OK TO LEAVE MESSAGE WITH DETAILED INFORMATION

___ LEAVE MESSAGE WITH A CALL BACK NUMBER ONLY (NO INFORMATION)

WRITTEN COMMUNICATION

___ OK TO MAIL TO MY HOME ADDRESS

___ OK TO MAIL TO MY WORK/OFFICE ADDRESS

___ OK TO FAX TO THIS NUMBER _____



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*** PLEASE READ AND MARK ALL THAT APPLY BELOW ***

DO NOT LEAVE ANY INFORMATION ON ANSWERING MACHINE

OK TO LEAVE TEST RESULTS, PHARMACY INFORMATION ON ANSWERING MACHINE OR WITH SPOUSE OR FAMILY MEMBER IF NOT OK PLEASE SPECIFY YOUR WISHES :

OK TO LEAVE INFORMATION WITH SPOUSE

OK TO LEAVE INFORMATION WITH CHILDREN

OK TO LEAVE INFORMATION WITH FAMILY MEMBER

OK TO REVEAL INFORMATION TO INSURANCE COMPANY

OK TO REVEAL INFORMATION TO OTHER PHYSICIANS

DO NOT CALL WORK NUMBER

DO NOT CALL HOME ONLY CALL _____

PLEASE NOTE ANY SPECIAL INSTRUCTIONS OUR OFFICE SHOULD USE WHEN TRYING TO REACH YOU REGARDING MEDICAL MATTERS OR RESULTS OF TESTING.

PATIENT SIGNATURE : _____

PRINT PATIENT NAME: _____

DATE: _____ PATIENT DOB : _____