EAST RIVER
GASTROENTEROLOGY & NUTRITION

REGISTRATION FORM

(PLEASE PRINT CLEARLY)

NAME: ____ BIRTHDATE: ________________
LAST FIRST MIDDLE INITIAL

STREET: ____ APT #: ______________________

CITY: __________________________________ STATE: ____________ ZIP CODE: __________________

HOME TEL #: _________________ CELL PHONE #: _________________ DAYTIME TEL #: _____________

SS #: ___________________________ EMAIL: ____

PHARMACY NAME/ADDRESS/TEL#: ____
(MANDATORY FOR PATIENTS FROM NEW YORK)

REFERRING PHYSICIAN (NAME, ADDRESS, #): ____

IN CASE OF EMERGENCY PLEASE NOTIFY: ____

TELEPHONE #: ___________________________ RELATIONSHIP: __________________________________

PRIMARY INSURANCE: ____

SECONDARY INSURANCE: _______________________________________

INSURED'S NAME (IF NOT SAME AS ABOVE): __________________________________ DOB: ____________

YOUR/PATIENT'S RELATIONSHIP TO INSURED (CIRCLE ONE): SELF SPOUSE CHILD OTHER

(PLEASE PROVIDE YOUR INSURANCE CARD TO THE STAFF SO THAT A COPY CAN BE MADE.)

THE FOLLOWING IS REQUESTED BY THE CENTER FOR MEDICARE SERVICES. PLEASE FEEL FREE TO ABSTAIN FROM ANSWERING ANY OR ALL OF THESE QUESTIONS:

GENDER: □ M □ F

RACE: _____________________________

ETHNICITY: ______________________

In accordance with the Federal Trade Commission "Red Flag Rules", effective May 1st 2009 we require a copy of your photo identification in order to help prevent identity theft. In order to stream-line our billing process and reduce the waste of paper and other resources, we ask to take an imprint of a valid credit card from all patients. This is effective January 1st, 2012. Please see a following page for more detail.

ADDITIONAL NOTICES

● I hereby acknowledge that I have received or had an opportunity to review the Notice of the Privacy Practices for Protected Health Information from East River Gastroenterology and Nutrition. ("HIPAA")

● I authorize East River Gastroenterology and Nutrition to process health insurance claims on my behalf and receive payment, and to release to the Social Security and Health Care Financing Administrations, or their intermediaries or carriers, or to the billing agent of this physician, any information needed for Medicare or third-party payor claims. I permit a copy of this authorization to be used in place of the original.

● I understand that payment is due at time of service.

● I understand that if I fail to keep an appointment for an office visit, or do not cancel by 1:00 pm the previous business day, a fee of $50 will be charged. I understand that if I fail to keep an appointment for a procedure (such as endoscopy, colonoscopy, or manometry), or do not cancel by 1:00 pm two business days prior to this procedure, I will be charged a fee of $250.

● I understand that obtaining all necessary insurance referrals for medical services at East River Gastroenterology and Nutrition is my sole responsibility. I am responsible for payment in full if services are rendered without the proper referrals in place.

● Advance Beneficiary Notice of Noncoverage (ABN): I understand that Medicare and other Third-party payors may not pay for all medical care, even some care that my healthcare providers have good reason to think is essential. I understand that if Medicare or another Third-party payor does not pay for a service, I am responsible for full payment according to the rules and regulations of Medicare or the Third-party payor.

● I understand that it is my responsibility to contact the Practice regarding my test results. (NOTE: The Patient Portal is an excellent way to do this!). Reminders and notices may also be sent to me by the Practice.

● I give my permission for the providers and staff of East River Gastroenterology and Nutrition to communicate with the following additional individuals about my medical care: ____

• I have received notice regarding Dietitian participation in commercial insurance.

SIGNATURE: ____________________________ DATE: ____________________________

CREDIT CARD IMPRINT POLICY

In an effort to stream-line our billing processes and to reduce the waste of paper, postage, and other resources, we will require an imprint of a valid credit card from all patients, beginning January 1st, 2012. The imprint will be kept in a secure, password-protected section of our electronic record system; access will be severely restricted even within the staff of the Practice. The purpose of keeping the imprint is to facilitate the payment of patient balances. (Typical charges would include balances left to you by your primary and secondary insurances after deductibles.) We become aware of these patient responsibilities when we receive an 'Explanation of Benefits' (EOB) from your insurance company. This may happen several weeks or even months after your visit to the practice.

You may elect not to provide any credit card information. If you do not provide a credit card to keep on file, you agree that you will settle all statements you receive within thirty days of issue or be subject to a 1% finance charge per billing cycle.

You have a choice as to how this credit card information can be used. Please check your preference below:

□ I would like the Practice to charge my card with balances as soon as they accrue. (i.e.: when the EOB arrives).

□ I would like to be sent a paper statement (bill). If payment is not sent within thirty days of receipt of the statement, the Practice may then charge my credit card.

□ I do not wish to provide a credit card number. I agree to the above terms.

You have a choice as to how we notify you in the event we charge your card:

□ I would like the Practice to notify me by phone any time a charge is placed.

□ I would like the Practice to notify my by phone any time a charge over $50 is placed

□ I do not need notification of charges placed.

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PATIENT/GUARDIAN SIGNATURE AND DATE

We thank you for your understanding and cooperation in this matter. We apologize for any inconvenience.

Eric S. Goldstein, M.D. and Tamara D. Freuman, M.S., R.D.

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