

Contact/Driver:

Name of person driving you home _____

Driver's Phone Number _____

Relationship _____

Is your driver staying in the waiting room? _____

Would you like your driver to speak with your doctor, with you after the procedure?

_____ Yes _____ No

For Office Use:

_____ Spoke with MD

_____ Spoke with Driver ETA: _____ Waiting Room _____

_____ Left Message _____ Time Called

Who is your primary care physician?

Are there any other physicians you would like to get a copy of today's report? If yes, please list below:

MORRIS ANESTHESIA GROUP, P.A.
PO BOX 26960
NEW YORK, NY 10087-6960
PHONE: 833-783-1796
FAX: 855-460-9151

AFFILIATES IN GASTROENTEROLOGY
25B HANOVER RD, SUITE 250
FLORHAM PARK, NJ 07932
PHONE: 973-301-0700
FAX: 973-301-0939

Assignment of Benefits

Thank you for allowing Affiliates in Gastroenterology/Morris Anesthesia Group to provide your anesthesia service. We look forward to providing you with our care. One of our complimentary services is to submit insurance and billing claims for you, easing your paperwork burden. In order for us to provide you with this service, please sign this Assignment of Benefits form:

I understand that signing this form authorizes: Affiliates in Gastroenterology/ Morris Anesthesia Group to submit claims on my behalf directly to my Insurance carrier. Anesthesia payment will be submitted directly from my Insurance carrier.

PRINT NAME: _____ **DATE:** _____

PATIENT SIGNATURE: _____

If someone other than the beneficiary is signing this form, please complete the following information for the person signing this form

Relationship to the beneficiary: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (_____) _____

FLORHAM PARK ENDOSCOPY CENTER

Network Disclosure Form

The Florham Park Endoscopy Center

I, _____ have been informed that this facility is

In-Network with my insurance plan

I have been notified of my co-payment, deductible or balance. I understand this is due the day of the procedure.

____ **Out of Network for my insurance plan and I understand the following**

My potential financial responsibility may exceed my copayment, deductible or coinsurance with my insurance plan.

I may be responsible for the amount, in excess, of the allowed amount my health insurance pays for the healthcare services I receive.

Florham Park offers payment plans that I may discuss with the billing company.

I acknowledge that I am knowingly and voluntarily accepting responsibility for any financial responsibility associated with the healthcare services I receive.

Signature of patient /legal Guardian

Name (Please Print)

Witness Signature

Date

Florham Park Endoscopy Center

FINANCIAL AGREEMENT

In the event that my insurance will pay all or part of the Center's and/or physician's and/or anesthesia charges, the Center and/or physicians which render service to me are authorized to submit a claim for payment to my insurance carrier. The Center, physician's office, anesthesia and/or pathology providers are not obligated to do so unless under contract with the insurer or bound by a regulation of a State or Federal agency to process such claim. We will expect payment of deductibles, co-pays and co-insurance at the time of service. Self-pay patients are expected to pay the agreed upon balance at the time of service. I am aware that I may receive a separate bill for any physician, anesthesia or pathology services performed from their respective companies.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign benefits to be paid on my behalf to Florham Park Endoscopy Center, my admitting physician or other physicians who render service to me. The undersigned individual guarantees prompt payment of all charges incurred for services rendered or balances due after insurance payments in accordance with the policy for payment for such bills of the Center, my admitting physician or other physicians who render service to charges not paid for within a reasonable period of time by insurance or third-party payer. I certify that the information given with regard to insurance coverage is correct.

RELEASE OF MEDICAL RECORDS

I authorize the Center, my admitting physician or other physicians who render service to release all or part of my medical records where required by or permitted by law or government regulation, when required for submission of any insurance claim for payment of services or to any physician(s) responsible for continuing care.

DISCLOSURE OF OWNERSHIP NOTICE

I have been informed prior to my surgery/procedure that the physicians who perform procedures/services at Florham Park Endoscopy Center may have an ownership interest in Florham Park Endoscopy Center. I have been provided a list of physicians who have a financial interest or ownership in the Center. The physician has given me the option to be treated at another facility/Center, which I have declined. I wish to have my procedure/services performed at Florham Park Endoscopy Center.

CERTIFICATION OF PATIENT INFORMATION

I have reviewed my demographic and insurance information on this date and verify that all information reported to the center is correct.

Email/Text/Automated Communication Informed Consent

I hereby consent and authorize Florham Park Endoscopy Center, any associated physician or other caregiver, as well as any of their related entities, agents, or contractors, including but not limited to schedulers, billing services, debt collectors, and other contracted parties, to use automated telephone dialing systems, text messaging systems, and electronic mail to provide messages (including pre-recorded or synthetic messages, text messages and voicemail messages) to me about my account, payment due dates, missed payments, information for or related to medical goods and/or services provided, exchange information, health care coverage, care follow-up, and other healthcare information.

Patient Signature _____ Date Signed _____ Printed Name _____

Parent/Guardian Signature (if patient is a minor) _____ Date Signed _____ Printed Name _____

Contact Information:
Mobile Phone Number: _____ Email address: _____

To revoke your consent to receive text messages or electronic mail from Florham Park Endoscopy Center, you may unsubscribe by replying and entering "Unsubscribe." If you would like to revoke other portions of this Consent to Contact Form, please contact the center directly in writing or by telephone.

PATIENT RIGHTS/ADVANCED DIRECTIVES INFORMATION

I have received written and verbal notification regarding my Patient Rights prior to my surgery/procedure. I have also received information regarding policies pertaining to ADVANCED DIRECTIVES prior to the procedure. Information regarding Advance Directives along with official State documents have been offered to me upon request.

Do you have an Advanced Directive for healthcare? Yes or No (circle) If No, would you like any information? Yes or No (circle)
Did the patient bring a copy to the Center? Yes or No (circle) If provided, a copy is placed in patient's medical record.

The undersigned certifies that he/she has read and understands the foregoing and fully accepts all terms specified above.

Signature of Patient or Responsible Party _____ Print Name _____

Relationship to Patient _____ Date Signed _____

I hereby authorize Florham Park Endoscopy Center and/or the physician performing my procedure today to communicate information regarding my procedure/results of my procedure/billing to/wilh:

My spouse/family member/other Name(s): _____ Initials _____

Leave a message on my answering machine: Yes _____ No _____ Initials _____

The undersigned certifies that he/she has read and understands the foregoing and full accepts all terms specified above.

Signature of Patient or Responsible Party _____ Print Name _____

Relationship to Patient _____ Date Signed _____

FLORHAM PARK ENDOSCOPY CENTER - NOTICE OF PRIVACY PRACTICES

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

<p>This Notice applies to ("Center") and health professionals when they provide services at the Center. Under federal law, your health information (known as "PHI") is protected and confidential. PHI includes information about your symptoms, test results, diagnosis, treatment, and related medical information and payment, billing, and insurance information. Your PHI may be stored and disclosed electronically.</p> <p>How We Use & Disclose Your PHI Treatment: We will use and disclose your PHI for treatment purposes. For example, nurses, physicians, and other members of your treatment team use PHI to determine the most appropriate course of care. We may also disclose PHI to other health providers who participate in your care. Payment: We will use and disclose PHI for payment purposes. For example, we may need to obtain authorization from your insurance company before providing treatment, determine whether you are enrolled or eligible for benefits and submit bills to your health plan. Health Care Operations: We will use and disclose your PHI to conduct our standard internal operations, including administration of records, credentialing, evaluation of the quality of treatment, arranging for legal services and assessing the care and outcomes of your case and others like it. The Center and professionals covered by this Notice will share PHI with each other as permitted by law for treatment, for payment, and for the Center's health care operations.</p> <p>Other Uses and Disclosures We May Make Family/Friends/Disasters: We may disclose limited PHI to family members or friends who are helping with your care or payment for your care and to those assisting in disaster relief efforts. For example, following a procedure, we will disclose your discharge instructions and PHI related to your care to the individual who is driving you home or who is otherwise assisting in your post-procedure care. Required by Law: We may disclose your PHI as required by law, such as to report gunshot wounds, suspected abuse or neglect, or similar injuries and events. For example, we may disclose your PHI to the U.S. Department of Health and Human Services if it requests PHI to determine that we are complying with federal law. Research: We may use or disclose PHI for approved medical research. Public health activities: We may disclose vital statistics, disease information, information related to recalls of dangerous products, and similar information to public health authorities. Health oversight: We may disclose PHI to assist in investigations and audits, eligibility for government programs, and similar activities. Judicial and administrative proceedings: We may disclose PHI in response to an appropriate subpoena, discovery request or court order. Law enforcement purposes: We may disclose PHI to law enforcement officials as permitted by law, such as to report a crime on our premises. Deaths: We may disclose PHI regarding deaths to coroners, medical examiners, funeral directors, and</p>	<p>organ donation agencies. Serious threat to health or safety: We may use and disclose PHI when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Military and special government functions: If you are a member of the armed forces, we may release PHI as required by military command authorities. We may also disclose PHI to correctional institutions or for national security purposes. Workers compensation: We may release PHI for workers compensation or similar programs providing benefits for work-related injuries or illness. Business associates: We may disclose PHI to business associates (individuals or entities that perform functions on our behalf) provided they agree to safeguard the information. De-identification: We may use and disclose your PHI to create information that is de-identified. In other words, we may remove identifiers in order to create information that is no longer individually identifiable as defined by law. We may also remove most PHI that identifies you from a set of data and use and disclose this data set for research, public health and health care operations, provided the recipients of the data set agree to keep it confidential. Health information exchanges: We may participate in one or more health information exchanges ("HIEs") and with your consent may electronically share your PHI for treatment and other permitted purposes with other HIE participants. HIEs allow your providers to efficiently access and use your PHI for treatment and other lawful purposes unless you opt out.</p> <p>In any other case, we will ask for your written authorization before using or disclosing your PHI. If you sign an authorization, you can later revoke that authorization to stop any future uses and disclosures by contacting the Contact Person listed below. Subject to limited exceptions, we will not use or disclose psychotherapy notes, use or disclose your PHI for marketing purposes or sell your PHI, unless you have signed an authorization.</p> <p>If we receive records from substance use disorder treatment programs subject to federal privacy rules (42 CFR Part 2) such records or testimony about their content cannot be used or disclosed in civil, criminal, administrative, or legislative proceedings against the individual unless based on written consent or a court order entered after notice and an opportunity to be heard is provided to the individual or us, as provided by 42 CFR Part 2. A court order authorizing use or disclosure must be accompanied by a subpoena or other legal requirement compelling disclosure before the requested substance use disorder record is used or disclosed.</p> <p>We may use Artificial Intelligence or (AI) tools, for purposes described in this Notice and as permitted by the HIPAA Rules. For example, we may use tools that record your interactions with our providers and staff to assist with</p>	<p>drafting notes or scheduling appointments.</p> <p>Individual Rights You have the following rights with regard to your PHI. Please contact the Contact Person listed below to obtain the appropriate form for exercising these rights. If you have given another individual a medical power of attorney, if another individual is appointed as your legal guardian or is authorized by law to make healthcare decisions for you (known as a "personal representative"), that individual may exercise any of the rights listed below on your behalf.</p> <p><input type="checkbox"/> You may request restrictions on certain uses and disclosures. We are not required to agree to a requested restriction, except for requests to limit disclosures to your health plan for purposes of payment or health care operations when you have paid in full, out-of-pocket for the item or service covered by the request and when the uses or disclosures are not required by law.</p> <p><input type="checkbox"/> You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.</p> <p><input type="checkbox"/> You have the right to look at or get a copy of your PHI. There may be a reasonable cost-based charge for copies.</p> <p><input type="checkbox"/> You have the right to request that we amend your PHI.</p> <p><input type="checkbox"/> You may request a list of disclosures of PHI about you except for disclosures made with your authorization and other exceptions.</p> <p><input type="checkbox"/> You have the right to obtain a paper copy of the current version of this Notice upon request, even if you have previously agreed to receive it electronically.</p> <p>Our Legal Duties/Changes to this Notice We are required by law to protect and maintain the privacy of your PHI, to provide this Notice about our legal duties and privacy practices regarding PHI, and to abide by the terms of the Notice currently in effect. We are required to notify affected individuals in the event of a breach involving unsecured PHI.</p> <p>We may change this Notice at any time and make the new terms effective for all PHI we hold. The effective date of this Notice is listed at the bottom of the page. If we change our Notice, we will post the new Notice in the waiting area. For more information about our privacy practices, contact the Contact Person listed below.</p> <p>Complaints/Contact Person If you are concerned that we have violated your privacy rights, you may contact the Contact Person listed below. You may also complain to the U.S. Department of Health and Human Services. The Contact Person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint. If you have any questions, requests, or complaints, please contact:</p> <p style="text-align: center;">Center Privacy Officer (973-410-1800)</p>
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Patient Name: _____

Patient Signature: _____

Date: _____

**Florham Park Endoscopy Center
195 Columbia Turnpike Suite 110
Florham Park, NJ 07932
973-410-1800**

PATIENT INFORMATION

BRING THIS FORM TO YOUR APPOINTMENT. DO NOT MAIL TO OFFICE

PATIENT: _____ AGE: _____ DATE OF BIRTH: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
HOME PHONE: _____ MOBILE PHONE: _____
MARITAL STATUS: _____ GENDER: _____

EMAIL ADDRESS

HOW DO YOU PREFER TO BE CONTACTED: HOME PHONE _____ MOBILE PHONE _____ EMAIL _____
DO YOU RESIDE IN A SKILLED NURSING FACILITY? _____
FAMILY PHYSICIAN (REFERRING PHYSICIAN): _____
DO YOU HAVE A LIVING WILL? _____ WOULD YOU LIKE INFORMATION ON LIVING WILLS? _____

PRIMARY INSURANCE INFORMATION

COMPANY: _____ TELEPHONE: _____
ADDRESS: _____ CITY, STATE, ZIP: _____
MEMBER # _____ GROUP# _____
NAME OF INSURED: _____ INSURED SSN: _____
INSURED DATE OF BIRTH: _____ RELATIONSHIP TO PATIENT: _____

SECONDARY INSURANCE INFORMATION

COMPANY: _____ TELEPHONE: _____
ADDRESS: _____ CITY, STATE, ZIP: _____
MEMBER # _____ GROUP# _____
NAME OF INSURED: _____ INSURED SSN: _____
INSURED DATE OF BIRTH: _____ RELATIONSHIP TO PATIENT: _____

EMPLOYMENT INFORMATION

EMPLOYER: _____ TELEPHONE: _____
ADDRESS: _____ CITY, STATE, ZIP: _____
RELATION TO PATIENT: _____ DATE OF INJURY: _____

EMERGENCY NOTIFICATION

CONTACT: _____ **TELEPHONE:** _____
RELATIONSHIP: _____

SIGNATURE (PATIENT OR REPRESENTATIVE)

DATE