GASTROENTEROLOGY ASSOCIATES
OF NORTH JERSEY, P.A.

Doctors Park 369 West Blackwell Street, Dover, NJ 07801
Tel (973) 361-7660 Fax (973) 361-0455

16 Pocono Road, Suite 210, Denville, NJ 07834
Tel (973) 627-7600 Fax (973) 627-7610

Barry Benerofe, M.D., F.A.C.G, Diplomate of the American Boards of Gastroenterology and Internal Medicine
Pamela G. Freedman, M.D., F.A.C.G., Diplomate of the American Boards of Gastroenterology and Internal Medicine
Matthew E. Krupnick, M.D., Diplomate of the American Boards of Gastroenterology and Internal Medicine
Sergey Rybalov, M.D., Diplomate of the American Boards of Gastroenterology and Internal Medicine
Jason Abfier, M.D., Diplomate of the American Boards of Gastroenterology and Internal Medicine

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Dear Patient,

Please complete the attached forms and bring them to the office on the day of your scheduled appointment. These forms ensure the accuracy of our records which is necessary for the claim payment process. Consequently, your insurance may require a co-payment or referral for specialist office visits. If so, please be sure to have them with you on the day of your visit. If you are unsure of your insurance plan's requirements, please contact the company or your primary care physician's office.

If you are being referred to this practice for a reason other than routine colonoscopy, please be sure to bring copied of any testing reports pertaining to your current diagnosis, such as CT scan, X-ray, blood test results, etc.

Finally, if your insurance plan requires a co-payment, or if you do not have insurance, please be aware that this office does accept credit cards (Visa, MasterCard, & Discover). We also accept cash and checks. We appreciate your understanding and cooperation and look forward to meeting you.

Sincerely,

Gastroenterology Associates of North Jersey

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Name: First_______________________Last______________________________MI____

Mailing Address____

City__________________________________State__________________Zip__________

Date of Birth__________________Sex__________Social Security #________________

Primary Phone_______________________ Alternate Phone_______________________

Marital Status________________________Student Status________________________

Primary Doctor_____________________Referring Doctor_________________________

Employer________________________________Occupation______________________
Employer Address____

Primary Insurance_________________________________ID #____________________

Policy Holder's Name___________________________Date of Birth________________
Policy Holder's Social Security #________________Relationship: self/spouse/child

Secondary Insurance______________________________ID#____________________

Policy Holder's Name___________________________Date of Birth________________
Policy Holder's Social Security #________________Relationship: self/spouse/child

Whom may we contact in case of an emergency?________________________________
Relationship to you_____________________Phone #____________________________

I verify the accuracy of the above information and I authorize the release of any medical information necessary to process insurance claims filed in my behalf. I also authorize payment of medical benefits directly to the physician.

Signature____Date________________

CONFIDENTIAL HEALTH HISTORY

Name____ Today's Date_____________________
Age_________ Birthday__________________ Date of last physical examination__________________________________
What is the reason for your visit?____

SYMPTOMS

Please circle the symptoms you currently have or have had in the past year:

GENERAL

Chills
Depression
Dizziness
Fainting
Fever
Forgetfulness
Headache
Loss of sleep
Loss of weight
Nervousness
Sweats

MUSCLE/BONE/JOINT

Pain, weakness, numbness in:

Arms Hips
Back Legs
Feet Neck
Hands Shoulders

GENITO-URINARY

Blood in urine
Frequent urination
Lack of bladder control
Painful urination

GASTROINTESTINAL

Appetite poor
Bloating
Bowel habit changes
Constipation
Diarrhea
Excessive hunger/thirst
Gas
Hemorrhoids
Indigestion
Nausea
Rectal bleeding
Stomach pain
Vomiting
Vomiting blood

CARDIOVASCULAR

Chest pain
High blood pressure
Irregular heart beat
Low blood pressure
Poor circulation
Rapid heart beat
Swelling of ankles

EYE,EAR,NOSE, & THROAT

Bleeding gums
Blurred vision
Crossed eyes
Difficulty swallowing
Double vision
Earache
Ear discharge
Hay fever
Hoarseness
Loss of hearing
Nosebleeds
Persistent cough
Ringing in ears
Sinus problems
Vision - Flashes/Halos

SKIN

Bruise easily
Hives
Itching
Change in moles
Rash
Scars
Sores that will not heal

MEN only

Breast lump
Erection difficulties
Lump in testicles
Penis discharge
Sore on penis
Other

WOMEN only

Abnormal Pap smear
Bleeding between periods
Breast lump
Extreme menstrual pain
Hot Flashes
Nipple discharge
Painful intercourse
Vaginal discharge
Other

Date of last period___________________
Date of last Pap smear________________
Have you had a mammogram?_________
Are you pregnant?____________________
Number of children___________________

CONDITIONS

Please circle conditions you currently have or have had in the past year:

AIDS
Alcoholism
Anemia
Anorexia
Anxiety
Appendicitis
Arthritis
Asthma
Bleeding disorders
Breast lump
Bronchitis
Bulimia
Cancer
Cataracts

Chemical Dependency
Chicken Pox
Diabetes
Emphysema
Epilepsy
Glaucoma
Goiter
Gonorrhea
Gout
Heart Disease
Hepatitis (of any kind)
Hernia
Herpes

High Cholesterol
HIV Positive
Kidney Disease
Liver Disease
Measles
Migraine Headaches
Miscarriage
Mononucleosis
Multiple Sclerosis
Mumps
Pacemaker
Pneumonia
Polio

Prostate problem
Psychiatric Care
Rheumatic Fever
Scarlet Fever
Stroke
Suicide attempt(s)
Thyroid problems
Tonsillitis
Tuberculosis
Typhoid Fever
Ulcers (of any kind)
Vaginal Infections
Venereal Disease

MEDICATIONS

Please list any medications you are currently taking:

ALLERGIES

To medications/substances

____
____
____

Pharmacy name:_______________________________ Phone #_________________

FAMILY HISTORY
Fill in health information about your family:

Relation	Age	State of Health	Age at Death	Cause of Death		Check if your blood relatives had any of the following: Disease	Relationship to you
Father						Arthritis, Gout	
Mother						Asthma, Hay Fever	
Brothers						Cancer	
						Chemical Dependency	
						Diabetes	
						Heart Disease, Strokes	
Sisters						High Blood Pressure	
						Kidney Disease	
						Tuberculosis	
						Other	

HOSPITALIZATIONS

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion (circle one)? YES NO

If yes, please give approximate dates________________________________

SERIOUS ILLNESS/INURIES

SERIOUS ILLNESS/INURIES	DATE	OUTCOME

PREGNANCY HISTORY

Year	Sex Complications, if any

HEALTH HABITS
Check which substances you use and describe how much you use

	Caffeine
	Tobacco
	Drugs
	Alcohol
	Other

OCCUPATIONAL CONCERNS
Check if your work exposes you to the following:

	Stress
	Hazardous Substances
	Heavy Lifting
	Other

Your occupation:

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor, or any members of his/her staff for any errors or any omissions that I may have made in completion of this form.

Patient signature____ Date__________________________

Physician signature____ Date__________________________

MEDICATION LOG

Patient____ Birthdate____________________________

Home Phone___________________ Work Phone __________________Occupation______________

Pharmacy____________________________________ Pharmacy Phone________________________

MEDICATION	DOSAGE	QTY.	FREQ.

Notes:____

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As required by Federal Law, this office has become HIPAA compliant.

We request that you update your patient information record as required by the guidelines.

This law was passed to ensure the privacy of our patients.

Thank you for your understanding.

If there are any persons that you wish to be able to access your medical information via the telephone or any other medium, please print the full name(s) below:

____

If there are any healthcare professionals that you wish to be able to access your medical information, please print the full name(s) and contact information below:

____

____

Your signature verifies that you understand the Notice of Privacy and Practices for Gastroenterology Associates of North Jersey, P.A. as required by the Federal Government.

Signature_______________________________________ Date____________________________

NOTICE OF PRIVACY POLICIES AND PRACTICES FOR

GASTROENTEROLOGY ASSOCIATES OF NORTH JERSEY

Dear Patient:

This notice describes how information about you may be used and disclosed and how you can get access to this information.

PLEASE READ THIS CAREFULLY.

At Gastroenterology Associates of North Jersey, we are committed to treating and using protected health information about you responsibly. This notice describes the personal information we collect and how and when we use or disclose that information. This notice is effective April 14, 2003 and applies to all protected health information as defined by federal regulations.

Each time you visit Gastroenterology Associates of North Jersey, a record of your visit is made. Typically, this record contains information about your visit including your examination, diagnosis, test results, treatment, as well as other pertinent healthcare data. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication with other health care professionals involved in your care.
- Legal document outlining and describing the care you received.
- A tool that you or another payer (your insurance company) will use to verify that services billed was provided.
- An education tool for medical health providers.
- Basis for public health officials who might use this information to access and/or improve state as well as national healthcare standards.
- A source of data for planning and/or marketing.
- A tool that we can reference to ensure that highest quality of care and patient satisfaction.

Understanding what is your record and how your health information is used helps you to ensure its accuracy, determine what entities have access to your health information, and make an informed decision when authorizing the disclosure of this information to other individuals.

YOUR RIGHTS:

You have certain rights under federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information.
- The right to amend or submit corrections to your protected health information.
- The right to receive an accounting of how and whom your protected health information has been disclosed.
- The right to receive a printed copy of this notice.

OUR RESPONSIBILITIES

Gastroenterology Associates of North Jersey is required to:

- Maintain the privacy of your health information.
- Provide you with this notice as our legal duties and privacy practices with respect to information we collect and maintain about you.
- Abide by the terms of this notice.
- Notify you if we are unable to agree to a requested restriction.
- Accommodate reasonable requests you have regarding communication of health information via alternative means and locations.

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next visit. The revised policies and practices will be applied to all protected health information that we maintain. We will not use or disclose your health information without authorization, except as described in this notice. We will also discontinue using or disclosing your health information after we have received a written revocation of the authorization.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

- We will use your health information for treatment. Your health information may be used by staff members or disclosed to other health care professionals for purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example: results of lab tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.
- We will use your information for payment. Your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated in order to pay for the service rendered to you.
- We will use your information for regular health operations. Your health information may be used as necessary to support the day to day activities and management of Gastroenterology Associates of North Jersey. For example: information on services you received may be used to support budgeting and financial reporting and activities to evaluate and promote quality.
- Business Associates. In some instances, we have contracted separate entities to provide services for us. These “associates” require your health information in order to accomplish tasks that we ask them to provide. Some examples might be a billing service, collection agency, answering services, and computer provider.
- Communication with family. Due to the nature of our field, we will use our best judgment when disclosing health information to a family member, other relatives, or any other person(s) that is involved in your care or that you have authorized to receive this information. Please inform this practice when you do not wish a family member or other individual to have authorization to receive your information.
- Research/Teaching/Training. We may use your information for the purpose of research, teaching, and training.
- Healthcare oversight. Federal law requires us to release your information to an appropriate health oversight agency, public health authority or attorney, or other federal/state appointee if there are any circumstances that require us to do so.
- Public Health Reporting. Your health information may be disclosed to public health agencies as required by law.
- Law Enforcement. Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.
- Appointment Reminders. This practice may use your information to remind you about upcoming appointments. Typically, this is done by a brief, nonspecific message left on your answering machine. If you do not approve of this method, please inform this practice.
- Test Results/Surgery Information/Refill Information. A brief message may be left on your machine or you may be notified mail. Please inform this practice if you do not agree with our methods.
- Other Uses and Disclosures. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind, you must submit a written revocation of authorization. However, your decision to revoke the authorization will not affect or undo any use of information that occurred prior to your notification.

FOR MORE INFORMATION OR TO REPORT A PROBLEM:

If you have complaints, questions, or would like additional information regarding this notice or the privacy practices of Gastroenterology Associates of North Jersey, please contact:

Privacy Official
Gastroenterology Associates of North Jersey
369 West Blackwell Street
Dover, NJ 07801
(973)361-7660

If you believe your privacy rights have been violated, please contact the aforementioned practice Privacy Official, or you may file a complaint with the Office of Civil Rights, US Department of Health and Human Services. There will be no retaliation for filing a complaint with either party. The address for Civil Rights Office is:

Office for Civil Rights
US Department of Health and Human Services
200 Independence Avenue SW
Room 509F HHH Building
Washington, DC 20201