GASTROENTEROLOGY CONSULTANTS OF NORTH JERSEY PC
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PATIENT DISCLOSURE CONSENT

HIPAA (Health Insurance Portability & Accountability Act) privacy rules give patients the right to request a restriction of their protected health information. The patient is also provided the right to request confidential communications or that communications to be made via alternative means such as sending information to the individuals place of employment instead of their home.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (check all that applies):

( ) Home Telephone_____

- ( ) OK to leave a detailed message
- ( ) Leave a message with a callback number only

( ) Contact person, other than self_____

- ( ) OK to leave a detailed message
- ( ) Leave a message with a callback number only

( ) Work Telephone_____

- ( ) OK to leave a detailed message
- ( ) Leave a message with a callback number only

( ) Cell Telephone_____

- ( ) OK to leave a detailed message
- ( ) Leave a message with a callback number only

PRIVACY RULES REQUIRE US TO TAKE REASONABLE STEPS TO LIMIT THE USE OR DISCLOSURE OF YOUR INFORMATION TO THE MINIMUM NECESSARY TO ACCOMPLISH THE INTENDED PURPOSE. USE AND DISCLOSURE PERMITTED WITHOUT PRIOR CONSENT IN AN EMERGENCY.

_____

Signature **Print Name** **Date**

Gary I. Gorodokin, M.D.

Board-Certified Gastroenterology/Hepatology

ATTENTION ALL PATIENTS

Due to the fact that there are many different programs to each insurance company, it has become almost impossible for the office to keep track of each patient's policy. You, as the policyholder, are responsible for obtaining the information needed prior to your visit. You can confirm your benefits by speaking to your insurance representative. Please, read and sign the following:

I understand and accept any requirements or limitations placed upon me by my specific Managed Care Organization or Insurance Plan. I am responsible for any medical or surgical deductible and/or co-insurance stated in my insurance plan. I understand that I am solely responsible to know such limitations and requirements in order to receive medical services in your specialty office. It is my responsibility to:

- obtain all necessary referrals/authorizations and present them to your staff prior to any medical services rendered to me
- keep track of the number of services authorized and the expiration dates. Provide a new insurance card if my insurance company changes.
- Pay all deductibles, co-insurance and other amounts deemed by my insurance to be patient responsibility
- know what services are and are not covered under my contract. I will be responsible for any payment if doctor's reimbursement for services provided to me would be denied by my health plan.

I have read the above information and have had the opportunity to ask questions about it.

_____

Signature **Date**

_____

Print Name