SJPEDGI
South Jersey Pediatric Gastroenterology LLC
John Y. Tung, M.D.

Child 1st name: _____ Mid Name: _____Last Name: _____

DOB: _____-_____-_____ Male_____ Female_____ Referring Doctor_____

Address_____City_____State_____ZIP_____

Mom CELL#_____ Dad CELL#: _____HOME#:_____

Legal Guardian EMAIL:_____state relation: _____

Pharmacy: _____Addr_____City_____State_____ZIP_____

Primary Insurance (OR LEGAL GUARDIAN) –Card/legal guardian doc must be available for office to copy.

INS: _____ Policy: _____Ded Amt:_____Co-ins:_____ specialist copay: $_____

Policy Holder/Legal Guardian: 1st Name: _____Last Name: _____ Relation_____

DOB: _____-_____-_____ Male_____ Female_____

Phone: CELL_____ WORK: _____ HOME: _____

Address (if different fr. above)_____City_____State_____ZIP_____

Employer: _____ Address:_____City_____State_____ZIP _____

Secondary Insurance (if available) OR LEGAL GUARDIAN:

INS: _____ Policy: _____Ded Amt:_____Co-ins:_____ specialist copay: $_____

Policy Holder/Legal Guardian: First Name: _____ Last Name: _____ Relation_____

DOB: _____-_____-_____ Male_____ Female_____

Phone: CELL_____ WORK: _____ HOME: _____

Address (if different fr. above) _____City_____State_____ZIP_____

Employer: _____ Address:_____City_____State_____ZIP _____

I am responsible for payments which includes deductibles, co-insurance, unpaid balances, costs incurred by collection services in case of non-payment, including reasonable attorney fees and court costs related to services rendered by SJPEDGI. With dependents of divorced parents, adopted children, state custody children, the person bringing the child is responsible for this payment. It is my responsibility to find out if Dr John Tung is in network with my insurance. I give permission to SJPEDGI to release any information, to appeal on my behalf to the insurance company and authorize assignment of all payments to be paid to SJPEDGI. A photocopy of this document shall be effective and valid as the original.

Signature: Date:

SJPEDGI NEW PATIENT HISTORY FORM

Patient Name _____DOB _____
Person completing form _____ Relation to Patient _____
Can you give consent for medical examination and procedures for this child? Yes No
Pain- Location of pain- right, left, upper, middle_____When did pain start? _____
Severity of pain eg 7/10 _____Sharp or Dull pain?_____ Pain moves anywhere-into back/chest?_____ How often-eg 10x a day, daily, _____ Anything makes pain worse or better?_____ . Related to school/stress/food _____
Anything else?_____
_____
Pooping problem? How often is there a poop-daily?_____Hard or soft?_____
Bloody____Block toilets_____ Did child poop on 1st day of life_____Veg/Fruits in diet_____Water intake enough?_____, Abdominal pain?_____ Abdominal swelling? ____
Dirty Underwear_____ Painful poop_____ Afraid to Poop_____ Potty trained?_____
Anything else? _____
Reflux/VOMIT- vomit frequency per day____ Projectile or wet burps_____ Bloody_____
Bile/green vomiting_____ Unable to breathe with vomiting_____ Turn blue_____
Turn Red_____ Pain/crying with this_____Formula used_____,
Thicken formula with cereal?_____How much cereal?_____ Which cereal_____
Duration of crying per day_____Swallowing problem _____
Anything else? _____
Weight Gain/Loss concern-_____ **Appetite concern-**_____
Feeding problems: _____
Food allergy to milk, eggs, soy, wheat, seafood, nuts?_____
Gas problems?_____ Related to Milk?_____Recent Antibiotic use_____
School problems?: _____ **School Absence?**_____
Any other problems:_____
_____
_____
_____
Medical tests done so far: _____
_____
Birth Birth Wt ____ Full Term?_____ Medical problems_____
Significant diseases: (eg. asthma, diabetes, autism, heart operations)
_____
_____
Immunization: up to date? _____ **DEVELOPMENT:**Roll over ____ Sit up_____ Walk _____Toilet Train____
ENVIRONMENTAL: TAP/City water_____ Well water_____ Mould_____
Smoke in house_____Pets in house? _____ Travel outside USA _____
MEDICATIONS: give dose and how many times a day medication taken.
_____
_____
******MEDICATION ALLERGY******-_____
SURGERIES and HOSPITALIZATION_____
_____

Review of Systems: **(Circle)**

General: weight loss without trying, sleepy and tired all the time, chills and night sweats
Blood/Circulation: Fatigue, Bleeding problems, Cold hands/feet
Heart: Fainting, Abnormal hear rate, Chest pains
Lungs: : Wheezing, Coughing, Shortness of breath
Skin: Acne, Psoriasis, Eczema
Endocrine: Diabetes, Growth problems, Overweight
ENT: Hearing loss, Ear infections, hoarseness
Eye: Glasses, Painful eyes, Red eyes
GI: Constipation , Diarrhea, Vomiting
Kidney: infection**,** Wet bed, Bloody urine
Musculoskeletal: Back pain, Stiffness Swollen joints
Neurology: Migraines, Headaches, Seizures Dizzyness
Psych: Suicidal thoughts, Anxiety Hyperactive
Allergies: Rash, Hives, Wheeze

Reviewed by Dr J Tung _____

Family History

Does any family member have a history of any of the following?

Food allergies _____
Anesthesia problems _____
Growth problems _____
Heart disease _____
Lung disease _____
Joint pain _____
Migraines _____
Irritable bowel _____
Chronic diarrhea _____
Constipation _____
GERD _____
Ulcers _____
Abdo pain _____
Ulcerative colitis _____
Crohn's disease _____
Celiac disease _____
Lactose Intolerance
Pancreas disease _____
Gall bladder dis. _____
Liver disease _____
High cholesterol _____

SOCIAL HISTORY **(circle or fill in)**

Are parents living together? _____
Who does the child live with?
Mother , Father, Stepfather, Stepmother
Childs lives in 2 homes/ parents divorced?_____
How may toilets at home?_____
How many people stay at home_____

School _____ Grade _____
Does child attend daycare? Yes No
What pets do you have?_____

Over 12 years old- do you take (circle)
Recreational drugs
Alcohol
Smoke

Living Will If patient >18 yr, do you have one?
Yes No

Cultural- do you have any language difficulty, disability or special needs required for communication with the doctor or medical staff?
Yes No

Ethnic group: circle
African American, Hispanic, Chinese, Japanese, Korean, Indian, Pakistani, Bangladesh, Middle Eastern, Arab, White/Caucasian, other

Diet: Vegetarian Lactovegan, Standard American

Use this space to add anything you would like me to know in addition to the above:

_____

_____

_____

_____

_____

_____

_____

_____

Name of patient _____ DOB _____ Date:

**** Please refer to **www.sjpedgi.com** This is our website for directions, links to **important & useful** information**. ****

Appointments

We ask that you arrive at least 10-15 minutes prior to your appointment. If you are 30 minutes late you may need to wait until the end of the office session or we may ask that you reschedule the appointment. Any patient who needs a referral will only be seen if they have an up to date referral. If not, you will need to prepay for the visit until a valid referral is received. The alternative will be for you to re-schedule the visit.

Guardianship papers

A parent or legal guardian must always be present with a minor. Custody papers must be provided before or at the time of the visit.

No Show and Re-booking Policy for clinic and procedures

Once an appointment is made, you must cancel >72 hours before the appointment so that we may allocate the time to another patient. Cancellations < 48 hours is a no show and a rebooking fee of $25 (not refundable) is charged. Please note that arranging any procedures require a significant amount of time by staff in our office and the Surgicenter. An endoscopy requires time commitment by at least 5 professionals and a room specially allocated to your child. If your child is ill on the day of the procedure, you must call our office at 609-625-8688 to let us know.

Telephone Calls

Due to the large volume of calls, we cannot answer all calls but will make our best effort to answer telephone messages in a prompt fashion. Dr Tung will take emergency calls through his emergency phone line which is 609 736 0761 after hours and weekends. When leaving messages, it is very important to speak **very clearly and slowly**, you must leave patient name, DOB and the best number to contact you.

Labs, X-rays and Biopsy results, medications

When Dr Tung request investigations or consultation or prescribe medications, it is the patients responsibility to follow ALL the instructions and get ALL these completed. Due to the large volume of results/tests, we are not able to check and remind you to get these completed. It is your responsibility to set up a follow up appointment to discuss these results. Our staff is NOT qualified and are instructed not to interpret the results over the phone. We do not routinely call results back to parents, our office policy is that Dr Tung will discuss these results with you at follow up visits, unless this is a life threatening result that requires immediate attention. Dr Tung summarizes results in his letter to your primary care physician after the follow up visit. All biopsy results are discussed 2 weeks after the procedure and that is why a follow up appointment must be made after every procedure.

Primary Care Physician

Dr Tung provides consultation care to patients and you must have a primary care physician or family doctor to care for your child's general health. Your primary care doctor will continue to care for all of your child's general medical needs and be available to answer most of your questions. Dr. Tung is always available to your primary care doctor to answer specific questions about the child's gastrointestinal condition.

Medication refills

The office has a medication refill line 609-625-8688 (x22). To avoid delays please be sure to leave the following information:

- Spelling of the child's first and last name, DOB, Medication name, Dose, and how often your child takes it per day
- Pharmacy name, phone number and/or fax, please speak clearly and call back number slowly to ensure accuracy

In some situations your insurance company will not pay for medications if there is a generic version of this medication. Dr Tung may adjust the prescription according to these guidelines in choosing the most appropriate medication for your child. Refills must be called in one (1) week prior to running out of the medication. If you have not been keeping up with your follow up visits, Dr Tung may not know if it is appropriate to refill your medication and will ask that you schedule a follow up visit. Please do not call for medication refills during night and weekend hours except in an urgent or emergent situation. Dr. Tung may not have ready access to your child's medical record, and he may only provide the requested medication for three (3) days until he can check your child's medical record.

Labs, X-rays, Ultrasound and Procedure Ordered It is your responsibility to be aware of the requirements of your insurance plan. You need to know where your insurance plan allows you to go for the above. Out of network transparency-please refer to website WWW.SJPEDGI.COM

Miscellaneous forms

The office will complete relevant form, letter of medical necessity and report pertaining to gastroenterology services received. Depending on the amount of paperwork involved please allow 5-7 business days to complete the forms. The charge for the service is $25.

Insurance Companies and Payments

We will submit claims for services rendered to your child on your behalf. This is not a requirement but a courtesy provided by medical practitioners. Ultimately you, as the parent, are responsible for all the charges if these are denied for ANY reason by the insurance company. You have a responsibility to keep your insurance policy current and also to update them of any queries in situations where there may be coverage provided by another insurance policy (Co-ordination of benefits). Many denials occur because your insurance company does not have this information. It is your responsibility to find out from your insurance company if any services to be provided will be covered. We will attempt to help you get pre-authorization for any procedures that require this.

Copays/Co-ins/Deductible/outstanding balances/Collections by small claims court.

Any copays/co-ins/deductible must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect from patients can be considered fraud. Please help us in upholding the law by paying at each visit. Any outstanding balances must be collected before the visit. If there is financial difficulty, please discuss with the staff to set up a payment plan. The task of collecting copay/co-ins/deductible from the 2nd insurance has become impossible and associated with a large number of denials. Our policy is to collect all copay/co-ins/deductible even if you have a 2nd insurance, we will provide you with a receipt of payment and you will be able to claim this directly from your 2nd insurance. Your bills are texted and emailed to you using a HIPPA compliant server. Please note that delinquent bills are sent for collection by small claims court; court charges and interest will be added to the final bill. Interest charged will be 1% per month starting from the date of service.

Copies of Medical Records

Dictations of all office visits are automatically faxed to your primary care physician. If you need a copy of your medical records, the handling charge will be $1 per page. There is an additional charge for postage. For faxes, the fee is $1 per page handling charge but there is no fee for the transmission. Results cannot be sent to a 3rd party without a signed release of information form.

I have read and agree with the above guidelines. A copy is available upon request.

Name:_____ Signed:

Name of patient: _____

New Jersey Department of Banking and Insurance

CONSENT TO REPRESENTATION IN APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS AND AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS IN UM APPEALS AND INDEPENDENT ARBITRATION OF CLAIMS

APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS

You have the right to ask your insurer, HMO or other company providing your health benefits (carrier) to change its utilization management (UM) decision if the carrier determines that a service or treatment covered under your health benefits plan is or was not medically necessary.* This is called a UM appeal. You also have the right to allow a doctor, hospital or other health care provider to make a UM appeal for you.

There are three appeal stages if you are covered under a health benefits plan issued in New Jersey. Stage 1: the carrier reviews your case using a different health care professional from the one who first reviewed your case. Stage 2: the carrier reviews your case using a panel that includes medical professionals trained in cases like yours. Stage 3: your case will be reviewed through the Independent Health Care Appeals Program of the New Jersey Department of Banking and Insurance (DOBI) using an Independent Utilization Review Organization (IURO) that contracts with medical professionals whose practices include cases like yours. The health care provider is required to attempt to send you a letter telling you it intends to file an appeal before filing at each stage.

At Stage 3, the health care provider will share your personal and medical information with DOBI, the IURO, and the IURO's contracted medical professionals. Everyone is required by law to keep your information confidential. DOBI must report data about IURO decisions, but no personal information is ever included in these reports.

You have the right to cancel (revoke) your consent at any time. Your financial obligation, IF ANY, does not change because you choose to give consent to representation, or later revoke your consent. Your consent to representation and release of information for appeal of a UM determination will end 24 months after the date you sign the consent.

INDEPENDENT ARBITRATION OF CLAIMS

Your health care provider has the right to take certain claims to an independent claims arbitration process through the DOBI. To arbitrate the claim(s), the health care provider may share some of your personal and medical information with the DOBI, the arbitration organization, and the arbitration professional(s). Everyone is required to keep your information confidential. The DOBI reports data about the arbitration outcomes, but no personal information will be in the reports. Your consent to the release of information for the arbitration process will end 24 months after the date you sign the consent.

CONSENT TO REPRESENTATION IN UM APPEALS AND AUTHORIZATION TO RELEASE OF INFORMATION IN UM APPEALS AND ARBITRATION OF CLAIMS

I, [PRINT NAME], by marking [√] (or [x]) and signing below, agree to:

[x] representation by [DrTung] in an appeal of an adverse UM determination as allowed by N.J.S.A. 26:2S-11, and release of personal health information to DOBI, its contractors for the Independent Health Care Appeals Program, and independent contractors reviewing the appeal. My consent to representation and authorization of release of information expires in 24 months, but I may revoke both sooner.

[x] release of personal health information to DOBI, its contractors for the Independent Claims Arbitration Program, and any independent contractors that may be required to perform the arbitration process. My authorization of release of information for purposes of claims arbitration will expire in 24 months.

Signature: _____ Ins. ID#:_____ Date: _____

Relationship to Patient: ☐ I am the Patient ☐ I am the Personal Representative (provide contact information on back)

* If the patient is a minor, or unable to read and complete this form due to mental or physical incapacity, a personal representative of the patient may complete the form.

Health Care Provider: The Patient or his or her Personal Representative MUST receive a copy of both sides/pages of this document AFTER PAGE 1 has been completed, signed and dated.

Name of patient _____ DOB _____Date:_____

AUTHORIZATION FOR TREATMENT AND RELEASE OF INFORMATION

I represent that I have the legal authority to authorize the examination and treatment of my child (patient) by South Jersey Pediatric Gastroenterology, LLC (SJPEDGI). I understand that the examination and treatment may include the use of x-rays, laboratory tests, photographs, medications, and other diagnostic procedures and tests. If surgery or invasive procedures are required, I understand that the surgery or the invasive procedure will be explained to me by the physician or physician's designee, and I will be asked to give additional written consent for such procedure. I understand that it is my responsibility to follow completely ALL the instructions for medications, to perform testing, consultation and follow up care as recommended by Dr John Tung.

I understand that in the course of treatment and in obtaining payment, SJPEDGI may share with insurance companies and other provider's medical information regarding the above-named child's treatment or condition. I consent to the sharing of such information. I understand that insurance companies sometimes deny care and payments and I give consent for Dr John Tung to appeal all denials for treatment and payment on behalf of the patient.

I consent to Dr. Tung to represent me in an appeal of adverse UM determination as allowed by NJSA 26:2S-11, and release of personal health information to DOBI, its contractors for the independent healthcare appeals program, and independent contractors reviewing the appeal. My consent to representation and authorization of release information expires in 24 months but I may revoke both sooner.

I also give consent for any designated member of SJPEDGI to communicate with the primary care, dentist, consulting health care professional, school health care profession, teacher, social worker, care assistant, home care company, pharmacy, daycare, medical daycare, and any medical facility to facilitate his medical care.

Initial

_____

ASSIGNMENT OF BENEFITS

I assign that payment of authorized benefits be made on my behalf to SJPEDGI for any services furnished to me or my covered beneficiaries by SJPEDGI physicians and health care providers. I authorize any holder of medical information about me or my covered beneficiaries to release my Health Insurance Plan such information needed to determine these benefits or the benefits payable for related services. If my Health Insurance Plan will not direct payment to SJPEDGI, I agree to forward to SJPEDGI all health insurance payments which I receive for the services rendered by SJPEDGI and its health care providers.

Initial

_____

Receipt of SJPEDGI Notice of Privacy Practices

SJPEDGI is required by the Privacy Standards of the Health Insurance Portability and Accountability Act of 1996 to provide each patient and his/her legal representative a copy of our Notice of Privacy Practices. We are also required to obtain a signed acknowledgement of receipt from each patient and his/her legal representative. We appreciate your cooperation in signing below to fulfill this requirement. A copy of this is also available on request and on our website www.sjpedgi.com

Initial

_____

CONSENT TO CONTACT:

I give consent for any person designated by SJPEDGI to call, fax, leave voice messages, text messages, attachments on text messages and emails to contact me for ALL purposes regarding my child or myelf including office appointments, all aspects of medical care, all aspects of billing, collection, legal and insurance issues.

: on my home answering machine
: my spouse cell phone
: my children or anyone residing at my home to pass on to me.
: my work number
: my personal fax number
: my cell phone numbers provided to SJPEDGI
: email which I have provided to SJPEDGI.

Initial

_____

Statement of Financial interest in Surgicenter

Dr John Tung has a financial interest as a shareholder in Summit Surgicenter, Atlanticare Surgicenter and Virtua Center for Surgery. Information on all insurance SJPEDGI is in network, is available on the website www.sjpedgi.com which I will check to confirm coverage.

I have received, read, understood and agree with the:
1. AUTHORIZATION FOR TREATMENT AND RELEASE OF INFORMATION
2. ASSIGNMENT OF BENEFITS
3. I ACKNOWLEDGE RECEIPT OF SJPEDGI NOTICE OF PRIVACY PRACTICES
4. CONSENT TO CONTACT
5. STATEMENT OF FINANCIAL INTEREST IN SURGICENTERS

SIGNATURE:

Name:

_____

Date

_____

SJPEDGI
South Jersey Pediatric Gastroenterology LLC
John Y. Tung, M.D.

Medical Record Release Authorization Form

I hereby authorize: _____

Office address: _____

_____

To release all medical records of my child/children to:

South Jersey Pediatric Gastroenterology, LLC.
5429 Harding Highway Suite 302, Mays Landing, NJ 08330
Fax 844 499 4491, Telephone 609-625-8688

Patient's Full Name: _____

Date of birth: _____

Patient's address: _____

Patient's phone number: _____

Parent/Guardian signature:

5429 Harding Highway, Suite 302, Mays Landing, NJ 08330 Tel (609) 625 8688 Fax (609) 625 4162
1 Britton Place, Suite 8, Echelon Professional Center, Voorhees, NJ 08043, Tel (856) 772 1100, Fax (856) 772 6200
www.sjpedgi.com