Anu Sampat, M.D.

4982 Hylan Blvd.
Staten Island, NY 10312

1340 Route 34S, Ste. B
Aberdeen, NJ 07747

Ph. 718-227-1282 fax 718-967-2524

First Name: _____ MI: _____ Last Name: _____

Date of Birth: _____Social Security Number _____-_____-_____

Marital Status: Single / Married / Divorced / Widowed **Sex:** Male / Female

Address: _____ Apt# _____

City: _____State: _____ Zip: _____

Home phone # _____ Work # _____

Cell # _____ Email Address _____

Emergency Contact Name: _____ Phone # _____

Pharmacy Name: _____ Phone # _____

Referred by: _____

Primary Care Physician: _____

Physician Address: _____

Physician Phone #: _____

Insurance Information

Primary Health Insurance: _____

Insurance ID #: _____ Subscriber Name: _____

Date of Birth: _____ Social Security Number _____-_____-_____

Employer: _____

Secondary Health Insurance: _____

Insurance ID#: _____ Subscriber Name: _____

Subscriber Date of Birth: _____ Social Security Number _____- _____-_____

I hereby authorize the release of any medical or other information necessary to process all medical insurance claims. I request payment of benefits be made for services rendered to the above listed medical provider.

_____ _____

Signature (Insured of Authorized Person) **Date**

Anu Sampat, M.D.

PATIENT PRIVACY NOTICE

ACKNOWLEDGEMENT FORM

The purpose of this form is to record acknowledgement of receipt of the Privacy Notice, as required by the Health Information Portability and Accountability Act (HIPPA). Should such acknowledgement be unobtainable, this form will document the practice's good faith in attempt to acquire such acknowledgement.

Part A: I, _____ , acknowledge receipt of the Privacy Notice and Practices.

Signed _____Relationship to Patient_____

Date_____

Part B: The practice made a good faith attempt to obtain from

_____, Acknowledgement of receipt of the Privacy Notice, but was unable to do so for the following reason(s):

Individual refused to sign: _____

An Emergency situation prevented us from obtaining it_____

Communication Barriers prohibited us from obtaining the authorization_____

Other: Please specify_____

Signed: _____Name of Employee_____

Date: _____

I, _____, give permission for the Anu Sampat, MD to release medical information to the following person(s).

Name _____ Phone # _____

Name _____ Phone # _____

DIGESTIVE DISEASE ASSOCIATES

GASTROENTEROLOGY & HEPATOLOGY

To Our Patients:

Please be advised that ALL test results will be given in a follow-up office visit only. These regulations are put in place because of patient privacy issues (HIPPA). We do not mean to inconvenience you but this is a necessary measure required by law. There will be no exceptions to this policy.

Thank you for your understanding in this matter.

Anu Sampat, M.D.

I fully agree and understand above policy:

***Patient Signature*: _____ *Date*:_____**