

Acknowledgement and Authorization (1/2)

Patient Name: _____ Date of birth (mm/dd/yyyy): ____/____/____

****Please initial each item in this section to confirm your acknowledgement and authorization****

- I have read, understand and agree with the **Office and Financial Policies** of Colorectal Care of New Jersey LLC.
Patient initial: _____
- I have read, understand and agree with the **Notice of Privacy Practices, Release of Information and Assignment of Benefits** of Colorectal Care of New Jersey LLC.
Patient initial: _____
- I authorize Dr. Karmina Choi to render medical care and treatment deemed necessary for my condition. I acknowledge that no guarantees have been made to me about my medical care and treatment. I understand that Dr. Choi may take photographs or recordings when necessary, and that a vendor representative may need to be present when the care or treatment requires using certain specialized equipment or devices.
Patient initial: _____
- I authorize Colorectal Care of New Jersey LLC to have access to and obtain my medication history.
Patient initial: _____
- I authorize Colorectal Care of New Jersey LLC to release my Protected Health Information required for treatment, payment and healthcare operations.
Patient initial: _____
- I hereby assign my insurance benefits for services rendered to be paid directly to Colorectal Care of New Jersey LLC.
Patient initial: _____
- I understand that I am financially responsible for any amount not covered by my health insurance plan, and I agree to immediately pay all amounts upon receipt of a medical bill from Colorectal Care of New Jersey LLC.
Patient initial: _____
- I authorize Colorectal Care of New Jersey LLC to maintain my credit card information on file for payment purposes as stated in Office and Financial Policies.
Patient initial: _____

****Please continue on the second page, then sign and date this document****

Acknowledgement and Authorization (2/2)

- I understand that I have a right to revoke this authorization by providing written notice to Colorectal Care of New Jersey LLC. However, this authorization may not be revoked if its employees or agents have taken action on the authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

Patient initial: _____

- I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign may limit the ability of Dr. Karmina Choi to care for me. However, it will not affect my eligibility for benefits or enrollment or payment for or coverage of services by my insurance carrier.

Patient initial: _____

Consent to automated phone calls and text alerts

Please initial **only the item(s) you consent to in this section**

If you do not want to receive automated phone or text alerts, skip this section

- I consent to receive automated phone calls on my preferred phone number from Colorectal Care of New Jersey LLC about appointments, notification of test results and other information relevant to my care.

Patient initial: _____

- I consent to receive automated text alerts on my cell phone from Colorectal Care of New Jersey LLC about appointments, notification of test results and other information relevant to my care.

Patient initial: _____

Patient Printed Name

Patient Signature

Date

If patient unable to sign, an authorized representative may sign below on behalf of the patient:

By signing this form, I attest that I am the legal representative of the Patient identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Patient's behalf with respect to this authorization form.

Legal Representative Printed Name

Legal Representative Signature

Date

Relationship to Patient

Reason patient unable to sign