DORDANEH MALEKI, MD, FACP
LINWOOD COMMONS
2106 NEW ROAD, UNIT D5
LINWOOD, NJ 08221
PHONE: 609-927-3888
FAX: 609-927-3988

set revised 10/25/17

Dear Patient,

Thank you for choosing Dr. Dordaneh Maleki, MD, FACP, a specialist in Gastroenterology/Hepatology.

We ask that you complete the attached paperwork bring it along with you the day of your visit. Your initial visit will be to meet with Dr. Maleki, and if required, any procedure(s) will be scheduled before leaving our office.

In addition, please bring:

- **Your CURRENT insurance cards, and photo ID**
- **Referrals (if your insurance requires one) with ALL the correct, understandable information.**
- **Your co-payment, due at the time of your visit. Accepted forms of payment are cash, and credit/debit cards. NO CHECKS.**
- **Any lab work or medical records you may have.**

If for any reason you are unable to make your appointment, please contact our office 24/48 business hours in advance for office visits / procedures prior to your appointment at 609-927-3888. Otherwise there would be a $50 late cancellation fee for office visit and $100 for procedures, added to your balance.

No- show for the initial visit will only be rescheduled after paying a $50 deposit or posting a credit card, which will be refunded or used towards your copayment upon your visit.

If you do not have ALL the information noted above (excluding labs, or medical records); you will have to be rescheduled for another appointment.

Thank you and we look forward to seeing you the day of your appointment.

Sincerely,

The staff at Dr. Dordaneh Maleki's office

Enclosures

Appointment Date & Time

_____

**Directions to our office are on the back of this letter.

DIRECTIONS TO:
DORDANEH MALEKI, MD, FACP

LINWOOD COMMONS
2106 NEW ROAD, UNIT D5
LINWOOD, NJ 08221
PHONE: 609-927-3888 FAX: 609-927-3988

DIRECTIONS FROM NORTH: Take the Garden State Parkway South and get off at Exit 36. You will be on Tilton Road. Take Tilton Road until you reach Route 9 (Rite-Aid, Dunkin Donuts, McDonalds, TD Bank). Take Route 9 South for approximately 4 – 4.5 miles. When you get into Linwood and the Central Ave light, continue south for approx. 2 miles. Some landmarks you will pass will be Northfield Community School on the left (the street numbers change through Northfield, HOWEVER continue south on Rt 9), Central Square Plaza on right, Mainland High School on left, and Linwood Professional Plaza on right. Our complex, called Linwood Commons is on the left hand side after you pass Linwood Professional Plaza. We are Unit D5,at the far end of building D.

DIRECTIONS FROM THE SOUTH: (Cape May) Take Parkway North, get off at Exit 29 Somers Point. Follow to Route 9 and make a left onto Route 9 North. Travel Route 9 North for approximately 2.5 miles. You will pass WAWA on right, CVS on left (Ocean Heights Ave), our office is about 2.5 blocks from that light. You will see a small BB&T Bank sign; make a right into our complex. We are Unit D5, at the far end of building D.

DIRECTIONS FROM NORTHFIELD: Take Route 9 (New Road) South for approximately 4 – 4.5 miles. When you get into Linwood and the Central Ave light, continue south for approx. 2 miles. Some landmarks you will pass will be Northfield Community School on the left (the street numbers change through Northfield, however, continue south on Rt 9), Central Square Plaza on right, Mainland High School on left, and Linwood Professional Plaza on right. Our complex, Linwood Commons, is on the left hand side after you pass Linwood Professional Plaza. We are Unit D5, at the far end of building D.

DIRECTIONS FROM SOMERS POINT: Take Route 9 (New Road) north, for approximately 2.5 miles. You will pass WAWA on right, CVS on left (Ocean Heights Ave), our office is about 2.5 blocks from that light, Linwood Commons. You will see a small BB&T Bank sign; make a right into our complex. We are Unit D5, at the far end of building D.

DIRECTIONS FROM ATLANTIC CITY: If taking the Black Horse Pike, head west until you reach Route 9 (Kerbeck Dealership on left, Nissan Dealership on right, Rite Aid across the street). Make a left at that light, and follow Route 9 South for approximately 6-7 miles. The street numbers change through Northfield, HOWEVER, continue south on Route 9. When you get into Linwood and the Central Ave light (Central Square Shopping on right, Linwood Care Center on right) continue south for approximately 2 more miles. You will pass Mainland High School on your left, Linwood Professional Plaza on right. Our complex, Linwood Commons, is on the left hand side pass Linwood Professional Plaza. We are unit D5, at the far end of building D.

DIRECTIONS FROM MARGATE, VENTNOR: If going over the Margate Bridge, head west over the bridge taking Mill Road towards Route 9. The light at Route 9 (Northfield Community School on left), make a left and continue on Route 9 for approximately 4 – 4.5 miles. The street numbers change through Northfield, HOWEVER, continue south on Route 9. Once into Linwood at the Central Ave light (Linwood Care Center on right, Central Square Plaza on right), continue for approx 2 more miles. You will pass Mainland High School on left, Linwood Professional Plaza on right, our complex, Linwood Commons, is on the left. We are unit D5, at the far end of building D.

REV. 6/28/17

DORDANEH MALEKI, MD, LLC

Revised 11/8/17

PAYMENT POLICY, GUARANTOR of ACCOUNT, HIPAA DISCLOSURES
CONSENT TO REPRESENTATION IN UM APPEALS
(609) 927-3888

I understand **payment is required at the time of the office visit including co-pays, balance payment, non-covered services or self-pay services.** I understand payment may be made by cash, credit/debit card (Visa, Master Card, American Express, or Discover). **Checks are not accepted.** A paid receipt will be provided to me upon demand for submission to my insurance carrier for reimbursement. I hereby assign all medical and/or surgical benefits; including major medical, to which I am entitled, to **Dordaneh Maleki, MD, FACP**. This includes Medicare, Medicaid, Blue Cross/Blue Shield, Oxford or any other insurance company. If I am covered by the insurance carriers with which Doctor Maleki participates, the office will bill directly my carrier provided that:

The provided service is a covered service, co-payments (if any) are met, deductible (if any) are met, and if required by my insurance carrier, an authorization (referral) form is presented to the office at the time of my visit. As Dr. Dordaneh Maleki is a Specialist, all HMO patients must have a referral from their primary care physician. It is the patient's responsibility to ensure that referral has not expired and has additional visits remaining.

In all cases, with or without insurance coverage any patient or patient's guardian is ultimately financially responsible for the fees incurred in their medical care with DR. DORDANEH MALEKI, MD, LLC.

I understand that I will receive a statement for any balance due after my carrier has processed the claim. I understand , acknowledge and am agreeable that I am responsible for the balance of my statement in full to Dr. Dordaneh Maleki, MD, LLC, within (30) days. If I am unable to pay the entire amount, I am responsible for immediately, upon receipt of the statement, call the office to arrange a payment plan. I further understand that in the event that my account is not paid, I shall be responsible for any and all costs of collection, including but not limited to an additional 35% fee if my account is forwarded to collection agency for collection. In addition, I further understand that if legal proceedings are necessary to collect the amount due, I will also be responsible for paying all attorney's fees plus court costs.

If I no-show or cancel less than 24/48 business hours from my office visit/procedure time, I will be charged $100 for procedures and $50.00 for office appointments. I understand that if I should pay by check, and the check is returned by the bank for non-sufficient funds, I will be charged the amount of the check plus a $30 processing fee. I also understand that I will no longer be able to pay by check for any monies owed to Dr. Dordaneh Maleki, MD, LLC. I understand that failure to pay my balance and/or arrange payments and follow that payment agreement will result in collection agency action, including payment of collection agency fees, and/or discharge from the practice. If I have any questions regarding my insurance coverage, I will call the member services number located on my insurance card.

I acknowledge that I have received the HIPAA Notice of Privacy Practices, have read, and signed it.

Consent To representation in UM Appeals and Authorization to Release of Information in UM Appeals and Arbitration of claims

I _____ by marking [√] or [×] agree to

[√] representation by Dordaneh Maleki, MD, LLC in an appeal of an adverse UM determination as followed by N.J.S.A. 26:25-LL 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 sooner.

[√] Release of personal health information to DOBI, its contractors for the independent: Claim Arbitration Program, and any independent contractors that may be required to perform the arbitration process. My authorization of release of information for purposes of claim arbitration will expire in 24 months.

Signature :_____ Ins#:_____ Date:_____

Relation to Patient : [ ] I am the patient [ ] I am the Authorized Representative, Parent, Guarantor

Name of the Authorized Representative, Parent, or Guardian _____

Relation to Patient _____ Representative Phone Number_____

US Mail Address_____

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Consent to Use and Disclosure of Protected Health Information

Your protected health information will be used by Dordaneh Maleki, LLC, or disclosed to others for the purpose of treatment, obtaining payment or supporting the day to day health care operations of the practice. Furthermore, I give consent that any persons who accompany me, with regard to private conversations I have with my doctor at Dordaneh Maleki, LLC regarding my mental condition shall be allowed to hear such conversations. It will also be within my rights to discuss my medical condition in private with the doctor, if I so chose. The person or persons will be asked to wait in the waiting room until I ask them to return.

I specifically authorize the use and/or disclosure of the following type of highly confidential information indicated by my initials next to the information type: *I understand that this will include information relating to (check if applicable):*

____AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection ____Psychiatric Care
____Genetic Information ____Communicable Disease(s) ____Treatment for alcohol and/or drug abuse ____Sexually Transmitted Disease(s)

I authorize the above person/organization and/or members of their staff to furnish the above information, including copies or faxed copies of the information as directed in the authorization. I further agree to release the facility and its employees and agents from all liability that may arise from release of information herein requested.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for the more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting Restriction on the Use or Disclosure of Your Information

You may request a restriction of the use or disclosure of your protected health information Dordaneh Maleki, LLC may or may not agree to restrict the use or disclosure of your protected health information. If Dordaneh Maleki, LLC agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of agreed upon restriction will be a violation of federal privacy standards.

I understand that I may revoke this authorization to release information in writing at any time, except to the extent that action has been taken in reliance thereon. I understand that this authorization will expire on _____. If I fail to specify an expiration date, event or condition, this authorization will remain in effect until submission in writing is received.

Reservation of Right to Change Privacy Practices

Dordaneh Maleki, LLC reserves the right to modify the privacy practices outlined in this notice.

Signature

I have received this consent form and give my permission to Dordaneh Maleki, LLC to use and disclose my health information in accordance with it.

***PLEASE WRITE the names below of which YOU WANT us to discuss your file with (Ex.; Spouse, friend, family member, etc.)

If you DO NOT want us to discuss your file with anyone-- PLEASE WRITE "NO ONE.***

1- _____ 2- _____ 3- _____

ACKNOWLEDGEMENT OF PRIVACY NOTICE – SIGN AND DATE BELOW

_____ _____ _____

Name of Patient (Print or Type) Signature of Patient Today's Date

_____ _____

Signature of Patient Representative (if needed) Relationship of Patient Representative to Patient

PLEASE CHECK MARK one or more of the following on how *you prefer* us to contact you:

Home Telephone	Cell Telephone	Written
__Detailed Message	__Detailed Message	__Detailed Message
__Limited Message	__Limited Message	__Limited Message

ADVANCED DIRECTIVE :Do you have an Advanced Directive or a Living Will: YES or NO If yes, where is it on file:_____