PATIENT INFORMATION FORM

NAME: ____ DATE:______________

SS#_____________________ AGE:_____ DATE OF BIRTH:___/___/______

ADDRESS:____SEX:____

____MARITAL STATUS:___
CITY STATE ZIP

INFORMATION REQUIRED TO BE COLLECTED BY GOVERNMENT:

RACE______________ ETHNIC BACKGROUND:______________________

PREFERRED LANGUAGE___________________________
PREFERRED METHOD OF CONTACT: __LETTER __CALL HOME __CALL CELL

PHONES: HOME:__________________CELL:_______________WORK:___________

EMPLOYER:____

EMERGENCY CONTACT:_____________________________PHONE:____________
RELATIONSHIP:___________________________

MAY WE LEAVE MESSAGES ON VOICE MAIL/ANS MACHINE:___YES____NO
LEAVE MESSAGE WITH FAMILY MEMBER:_____YES_____NO INITIAL:_____

E-MAIL ADDRESS:___________________________________(OPTIONAL)

REASON FOR VISIT:____

ALLERGIES:____
DO YOU HAVE A LATEX ALLERGY?______________

DO YOU HAVE SLEEP APNEA?______YES _______NO

PRIMARY CARE PHYSICIAN:____

SPOUSE'S NAME:___________________________________ DOB:___/___/______

PHARMACY NAME:________________________________ADDRESS:__________________________

MAIL ORDER PHARMACY:____

PLEASE READ AND **SIGN THE REVERSE SIDE.** THANK YOU.

REVISED 12/7/11.

This consent is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights for privacy with respect to your health care information.

CONSENT FOR CARE

I, with my signature, authorize Center for Digestive Health Inc., and any employees working under the direction of the physician to provide medical care for me, or to this patient for which I am the legal guardian. This medical care may include services and supplies related to my health (or the identified person) and may include (but not limited to) preventative, diagnostic, therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or review of physical or mental status/function of the body and the sale or dispensing of drugs, devices, equipment or other items required and in accordance with a prescription. This consent includes contact and discussion with other health care professionals for care and treatment.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign benefits to be paid, on my behalf, to Center for Digestive Health, Inc. and/or Drs. Neil Jacobson, Michael Kirsch, Franjo Vladic, Eshwar Punjabi, Nicholas Golden; and/or CDH Endoscopy Center for any service furnished me by that provider. I understand and agree to be financially responsible for charges not paid for within a reasonable period of time by insurance or other third party payer, and certify that the information given with regard to insurance coverage is correct.

RELEASE OF INFORMATION

I authorize the providers rendering service to release all or part of my medical records when required for submission of any insurance claims for payment of services rendered. I further consent to the use for any practice operational needs as identified in the practice privacy notice. The providers, their agents, servants and employees who render services to me are hereby released from any and all liabilities of any nature that may arise from the release of such information.

FINANCIAL AGREEMENT

If you have insurance, we will help you receive maximum benefits by filing for you. However, we will expect payment of co-pays, coinsurance, and deductibles at the time of service. The undersigned individual guarantees prompt payment of all charges incurred. Fees related to collection of delinquent accounts will be the obligation of the patient. ALSO NOTE: Due to many changes in insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay aware of the changes, it is not always possible. Most insurance carriers cover medically necessary services and some, but not all, cover non-acute and/or screening services. **IT IS YOUR RESPONSIBILITY TO KNOW YOUR OWN COVERAGE.** In the event your services are not covered by your policy, you, as the patient, will be financially responsible for all costs incurred. Please remember, **YOUR INSURANCE POLICY AND COVERAGE IS BETWEEN YOU AND YOUR INSURANCE CARRIER,** not with the insurance carrier and this office. **DUE TO THE FOREGOING INFORMATION, WE STRONGLY URGE YOU TO CHECK WITH YOUR INSURANCE CARRIER PRIOR TO ANY DIAGNOSTIC TESTING BEING PERFORMED; i.e. lab work, procedures and MRI/CT's.**

CONSENT RELATED PRIVACY NOTICE

I have had a chance to review the Practice Privacy Notice as part of the registration process. I understand that the terms of the Privacy Notice may change and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions. If it does agree to my restrictions on PHI use, it is bound by that agreement.

I understand that this practice may refuse me services if I refuse to sign this consent/authorization. I may revoke this consent at any time, but the practice may refuse further services at that time.

PATIENT AGREEMENT

I have been notified by the office of Center for Digestive Health that it is my responsibility to check with my insurance carrier. I also certify that I have read and do understand the foregoing, and I personally and fully accept the terms specified above and understand that I am ultimately responsible for all charges related to services rendered.

______________________________	______________________________
Signature	Signature of Guardian/Responsible party
______________________________	______________________________
Date	Date
______________________________	______________________________
Print name	Relationship to patient

Copy of Practice Privacy statement signed or initialed with patient/guardian on:___________________________
Patient unable to sign privacy statement due to: