CENTER for DIGESTIVE MEDICINE

PATIENT INFORMATION

Name:		Sex: Female ◯ Male ◯
Date of Birth: / /	Social Security No:	
Address:		Apt No. / Suite:
City:	State:	Zip Code:
Telephone:	Cellular	
Email Address:		
Language:	Race:	Ethnicity:
Marital Status: Single ◯ Married ◯	Divorced ◯	Widowed ◯ Separated ◯
Employer:		Telephone:
Referring Physician:		Telephone:
Reason for Visit:		
Emergency Contact:		Telephone:

INSURANCE INFORMATION

Primary Insurance:		Telephone
Subscriber:	Subscriber Date of Birth:	/ /
Policy No.	Group No.	Effective:
Secondary Insurance:		Telephone
Subscriber:	Subscriber Date of Birth:	/ /
Policy No.	Group No.	Effective:

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS:

I hereby authorize payment directly to Center for Digestive Medicine of benefits due to me from my Insurance Company otherwise payable to me. I further authorize the release of any medicalinformation required by my insurance carrier(s) and to any Healthcare Provider involved in my treatment upon written or oral request of such provider. A copy of this authorization may be used in lieu of the original. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers of any information needed for this or a related Medicare claim.

I understand that I am fully responsible for the payment of all charges that are not covered and paid for by the insurance. I further understand that I shall be wholly responsible for all collection charges. This includes Court cost reasonable attorney fees incurred in any attempts to collect delinquent unpaid charges and all charges shall accrue intrest at the rate of eighteen percent (18%) per annum from the initial billing date.

Patient's Signature:_____ **Date:**_____

Please attached copy of Drivers License and Insurance Card

Clear Form

CENTER for DIGESTIVE MEDICINE

Notice of Privacy Practices Summary

Effective April 1,2003

You have our pledge and commitment to protect your medical information. We understand that medical information about you and your health is very personal. In fact, we are required by law to protect the privacy of your medical information and to provide you with a Notice of Privacy Practices, which describes:

How Medical Information about You May Be Used and Disclosed and How You can Access This Information.

We are requiered by law to have your written authorization before we use or disclose to others your medical information for purposes other than providing or arranging for your health care, the payment for or reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment.

We may be required or permitted by certain laws to use and disclose to other purposes without your authorization.

You also have important rights, which include:

- The Right to Inspecting and copy the Protected Health Information (PHI) we maintain about you
- The Right to request restrictions of your Protected Health Information (PHI)
- The Right to request to receive confidential communications from us by alternative means or at an alternative location
- The Right to request an amendment of Protected Health Information (PHI)
- The Right to receive an accounting of certain disclosures we have made of your Protected Health Information (PHI)
- The Right to complain if you feel your rights have been violated

We have available a detailed Notice of Privacy Practices which fully explains Notice from time to time and a copy is available by calling our office. You have a right to receive a copy of our most current notice in effect if you have any questions, concerns or complaints about the Notice please contact our Privacy Officer at 305 273-6266 or via fax at 305 273-6520

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability Act of 1996 (HIPPA) that I have cetain rights to privacy regarding my protected health information I understand that the information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among multiple health care for providers who may be involved in my treatment directly or indirectly
- Obtain payment from third part payers
- Conduct normal healthcare operation such as quality assessments and physical certification

I have received a summary of Center for Digestive Medicine Notice of Privacy Practices, but know that I can contact their Privacy Officer to obtain a detailed Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information.

I understand that this organization has the right to change it's Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree that you are bound to abide by such restrictions.

Patient name: _____

Signature: _____ Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment of Notice Of Privacy Practices but was unable to do so and documented below:

Date:	Initials:	Reason:

Please attached copy of Drivers License and Insurance Card

Clear Form

CENTER for DIGESTIVE MEDICINE

Patient Financial Consent

Deductibles may be applied to *Center for Digestive Medicine, PLLC* or *Gastro Anesthesia Services, LLC*, creating an overpayment.

I, _____, authorize *Center for Digestive Medicine, PLLC* or *Gastro Anesthesia Services, LLC* to reimburse each other directly if my deductible has not been met at either entity.

_____ _____

Patient Signature Date

_____

Consentimiento del Paciente Financiera

Deductibles pueden ser aplicados a *Center for Digestive Medicine, PLLC* o *Gastro Anesthesia Services, LLC*.

Yo, _____, autorizo *Center for Digestive Medicine, PLLC* o *Gastro Anesthesia Services, LLC* reembolsarse mutuamente si mi deducible no hubiera sido cubierto en una de las facilidades.

_____ _____

Firma del Paciente Fecha

Please attached copy of Drivers License and Insurance Card.
Por Favor Incluya Copia de la Licensia de Manejar y Tarjeta de Seguro.

Clear Form

A. Notifier: Center for Digestive Medicine/Gastro Anesthesia Services

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If your insurance doesn't pay for any service listed under option **D.** which is being recommended by your healthcare provider, you will be considered the responsible financial party.

Your insurance holds the right to not pay for everything, even some care that you or your health care provider have good reason to think you need. You hold the right to receive or not receive those services.

D.	E. Reason Insurance May Not Pay:	F. Estimated Cost
OFFICE VISITS ANESTHESIA FOR PROCEDURE SCREENING/NONSCREENING COLONOSCOPY ENDOSCOPY FIBROSCAN ULTRASOUND	NON-COVERED NON-CONTRACTED THEIR DETERMINATION OF NECESSITY DEDUCTIBLE/COINSURANCE/COPAYS APPLIED	VARIES

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the services under **D.** listed above.

G. OPTIONS: Check only one box. We cannot choose a box for you.

◯ **OPTION 1.** I want the **D.**_____listed above. You will be asked to pay now, but I also want my insurance to be billed. I understand that if my insurance doesn't pay, I am responsible for payment, but **I can appeal to my insurance.** If my insurance does pay, you will refund any payments I made.

◯ **OPTION 2.** I want the **D.**_____listed above. I understand that I will be held responsible for any and all payments if my insurance does not pay. I will not pay today but **I understand that I will be financially responsible if my insurance does not pay.**

H. Additional Information:

I. Signature:	J. Date:

Clear Form

Please Download Form, Complete and Save Form

Email as an attachment to:**centerfordigestivemedicine@gmail.com** or you may Print Completed Saved Form and FAX to: **305.273.6520**

Please do not forget to attach copy of Drivers License and Insurance Card .

Center for Digestive Medicine **Gastro Anesthesia Services**

7887 N. Kendall Drive, Ste. 101
Miami, FL. 33156