GASTROENTEROLOGY ASSOCIATES OF GAINESVILLE, P.C.
GAINESVILLE ENDOSCOPY CENTER, LLC
BRASELTON ENDOSCOPY CENTER, LLC

PATIENT INFORMATION

PLEASE PRINT

Last Name: _____ First: _____ MI: _____

Gender: _____ Date of Birth: _____ Social Security #: _____

Address:_____
*** If P.O. Box please give street address also.

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

Referring Doctor: _____

Primary Care Doctor: _____

Race: _____ Marital Status: (circle one) S M W D

Language: (circle one) English Spanish Other

Employer: _____

Address: _____

City: _____ State: _____ Zip Code: _____

How did you hear about us? (circle one)

Newspaper Shopping Cart Radio Billboard Phone Book Internet Health Fair

Facebook Page Friend/Family PCP/Other Physician

SPOUSE INFORMATION

Last Name: _____ First: _____ MI _____

DOB: _____ Social Security #: _____

GASTROENTEROLOGY ASSOCIATES OF GAINESVILLE, P.C.
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NOTICE OF PRIVACY PRACTICES

I have been notified of the **"NOTICE OF PRIVACY PRACTICES"** for my records.

Date: _____ Initials: _____

ALTERNATIVE CONTACT INFORMATION

I hereby authorize GASTROENTEROLOGY ASSOCIATES OF GAINESVILLE, P.C./GAINESVILLE ENDOSCOPY CENTER, LLC/BRASELTON ENDOSCOPY CENTER, LLC to contact me or leave messages for me at my place of work.

Date: _____ Initials: _____

I hereby authorize GASTROENTEROLOGY ASSOCIATES OF GAINESVILLE, P.C./GAINESVILLE ENDOSCOPY CENTER, LLC/BRASELTON ENDOSCOPY CENTER, LLC to leave messages on my home answering machine or cell phone regarding appointments and to inform me that laboratory results are available. The laboratory results are **NEVER** left on the answering machine. I realize that I must call the office to get them.

Date: _____ Initials: _____

HIPAA DESIGNATION AND EMERGENCY CONTACT

I _____ DO _____ DO NOT authorize GASTROENTEROLOGY ASSOCIATES OF GAINESVILLE, P.C./GAINESVILLE ENDOSCOPY CENTER, LLC/BRASELTON ENDOSCOPY CENTER, LLC to discuss my appointments, medical evaluation, treatment, my account and results to RELATIVES OR OTHER PERSONS as indicated:
Please make sure to provide an alternate number other than your phone number for these contacts.

Authorized person(s): _____ Relationship: _____Phone #_____

Authorized person(s): _____ Relationship: _____Phone #_____

Signature: _____ Date: _____

FINANCIAL AGREEMENT

I request that payment of authorized benefits be made to **GASTROENTEROLOGY ASSOCIATES OF GAINESVILLE, P.C./GAINESVILLE ENDOSCOPY CENTER, LLC/BRASELTON ENDOSCOPY CENTER, LLC**. I authorize any holder of my medical information to release to the Centers for Medicare and Medicaid Services (CMS) or commercial insurance and their agents any information needed to determine the benefits or the benefits payable for related services.

Signature: _____ Date: _____

I hereby authorize the release of any confidential medical information, including information related to psychiatric care, drug and alcohol abuse, and HIV/AIDS, necessary to process insurance claims or any other medical information that is required for any health care related utilization review or quality assurance activities or to any healthcare professional requiring this information in order to treat me.

I hereby assign and authorize payment to **GASTROENTEROLOGY ASSOCIATES OF GAINESVILLE, P.C./GAINESVILLE ENDOSCOPY CENTER, LLC/BRASELTON ENDOSCOPY CENTER, LLC** for all medical and/or surgical benefits including major medical policies, to which I am entitled under any insurance policy or policies, any self-insurance program, or any other type of benefit plan. I understand and acknowledge that this assignment of benefits does not relieve me of my financial responsibility for all medical fees and charges incurred by me or anyone on my behalf. I hereby accept such responsibility, including but not limited to, payment of those fees and charges not directly reimbursed to **GASTROENTEROLOGY ASSOCIATES OF GAINESVILLE, P.C./GAINESVILLE ENDOSCOPY CENTER, LLC/BRASELTON ENDOSCOPY CENTER, LLC** by any insurance policy, self-insurance program or other benefit plan.

You agree, in order for us to collect any amounts that you may owe, we may contact you at any number associated with your account including wireless telephone numbers. We may also contact you using and e-mail address that you provide. Methods of contact may include pre-recorded/artificial voice messages and/or automatic dialing devices.

This authorization shall remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. I understand that I have the right to receive a copy of this authorization.

_____ _____

PATIENT SIGNATURE *(or Parent/Guardian Providing Authorization)* **Date**

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FINANCIAL POLICY

- **We participate in most insurance plans, including Medicare.**

  1. It is your responsibility to check with your plan prior to your visit to make sure we are participating physicians. Failure to do this could result in reduced payments by your insurance company.
  2. **We do not file automobile, general liability, homeowner's or workman's compensation insurance.**
  3. If you have HMO/POS insurance, it is your responsibility to obtain a referral number from your PCP prior to being seen. If you fail to obtain this, the bill is your responsibility.

- **You and your insurance company are responsible for your bill.**

  1. Knowing your insurance benefits is your responsibility.
  2. Any questions concerning your coverage should be directed to your insurance company.

- **If your primary insurance company requires a co-payment, you must make the co-payment at the time of service.**

  1. Failure to pay your co-pay at the time of service will result in a **billing fee of $25.00**. ***Please remember that we are contractually obligated by your insurance company to collect your co-pays at time of service.***
  2. The balance of your charges will be billed to your insurance company. After payment of insurance company, any remaining balance will become patient responsibility which is due upon receipt of statement.

- **Proof of current, valid insurance must be provided at time of service.**

  1. If you do not provide this information, you will be considered a self-pay patient.
  2. Self-pay patients are required to pay their office visit charges in full. *Please ask about your advance payment responsibility when making your appointment.*
  3. Failure to pay your office visit charges at the time of service will result in a billing fee of $25.00.
  4. You will be billed for the balance of your charges. Payment in full will be expected with receipt of your statement.

- **For procedure appointments you may be charged $100.00 if your procedure is not cancelled within 48 hours or if you do not show for your appointment.**

- **Failure to receive your statement does not relieve you of your financial obligation. It is your responsibility to notify us of any changes in your billing information.**

- **We accept cash, checks, money orders, and major credit cards.**

  1. Returned checks are subject to a $25.00 return check fee.

- **Past due accounts are subject to our collections process and any fees assessed by a collection agency.**

_____ _____

Patient Signature (*or responsible party*) **Date**