Digestive Disease Consultants

PATIENT INFORMATION		
Name:	**Birth date:**	**SSN:**
RELATIVE OR FRIEND TO NOTIFY IN CASE OF EMERGENCY/PHONE:	**Patients Email:**	
Pharmacy Name, Street, City:	**Primary Care Doctor:**	

I agree to pay for any and all medical services I receive from the doctors/providers of this practice that my insurance company refuses to pay, for whatever reasons. This office will file a claim in my behalf, however if my insurance company refuses to pay, for whatever reason (e.g. non-covered service, does not pay for preventative medical visits, my failure to secure a referral from my primary care physician), I will pay for the service upon written/verbal notice of their refusal. I further agree and understand that this office can only code and file a claim for my visit(s) with a diagnosis that was encountered and documented in my medical record. Thus, to ask this office to change a diagnosis code solely for the purpose of securing reimbursement from any insurance carrier is inappropriate and may result in a fraudulent act(s). I also understand that any **delinquent accounts are subject to late fees.**

***** Notice for Medicare AND some other insurances: Deductibles for screening colonoscopies may be waived by your insurance, however, if during the colonoscopy the procedure requires intervention, i.e., biopsy, polyp removal, etc, then there will be a deductible amount applied by your insurance. Please check with your insurance. *****

Authorization: I consent to any medical diagnosis, therapeutic, or minor surgical procedure rendered to the patient under the supervision of the physicians. I hereby recognize that the practice of medicine and surgery is not an exact science and I acknowledge that no one has made any representation, guarantee, or warranty to me regarding the results to be achieved by any treatments or examinations that I (or the patient) will receive as a result of services. I authorize release of my patient records, including alcohol and drug abuse records protected under the regulations in Code 42 of the Federal Regulations, Part 2, if any; psychological services records, if any; social services records, if any; including communications made by me to a social worker or psychologist; records of Human Immunodeficiency Virus (HIV) testing including results, if any; records of treatment for Acquired Immune Deficiency Syndrome (AIDS), if any; and records of a communicable disease, if any; to my insurance company(s) for the purpose of payment of bill and to my health care provider for continuity of care. I authorize and request my insurance company to pay directly to the provider the amount due for medical care. In addition, I understand that I will be responsible for any amounts that are not covered by my insurance.

I understand that if any employee, physician, or agent of Digestive Disease Consultants sustains a percutaneous (through the skin), mucous membrane (through the mouth or eye), or open wound exposure to my blood or other bodily fluids, I may be tested for Human Immunodeficiency Virus (HIV) which causes Acquired Immune Deficiency Syndrome (AIDS).

I hereby certify that the contents of this form are understood by me. Paragraphs or lines that I choose not to pertain to me, if any, were stricken before I signed:

_____ _____ _____

Signature **Date (valid one year)** Witnessing Signature Only

CONSENT FOR USE AND DISCLOSURE OF YOUR HEALTH INFORMATION

Our purpose in asking you to sign this form is to inform you that this office may share your information with other providers who are involved in your care as appropriate.

The uses and disclosures by this office of your health information are necessary and will be used by this office in connection with your treatment, our obtaining payment for treatment and services that this office provides to you and so that this office can conduct its health care operations.

Please carefully review the Notice of Privacy Practices Form that this office has prepared and is offering to you today. Please also see our Notice of Privacy Practices Form for a more detailed discussion of the meanings of "treatment", "payment", and "health care operations."

You have the right to review our Notice of Privacy Practices Form prior to signing the consent. Please be advised that this office may revise this Notice from time to time. Any such revisions of this form will be made available to you at our office.

You should also review carefully this notice because it contains a list of rights that are available to you with respect to this office's use and disclosure of your protected health information. These rights include your right to request restrictions on our use and disclosure of your information.

You have the right to revoke this consent at any time, in writing.

If you do not sign this consent or choose to revoke your consent, we will not be permitted to use or disclose information for purposes of treatment, payment or healthcare operations, and we may therefore choose to discontinue providing you with healthcare services.

BY SIGNING BELOW, YOU ACKNOWLEDGE THAT YOU HAVE READ AND UNDERSTAND THIS CONSENT AND THIS OFFICE'S **NOTICE OF PRIVACY PRACTICES FORM**. YOU FURTHER ACKNOWLEDGE THAT YOU HAVE BEEN **OFFERED** (circle one) **RECEIVED** A COPY OF THIS OFFICE'S **NOTICE** TO TAKE WITH YOU.

_____ _____

Patient Signature Date signed

_____

Witness

Listed below are persons to whom Digestive Disease Consultants may discuss your medical information:

Name_____Date of Birth_____

Name_____Date of Birth_____

Name_____Date of Birth_____