

**Center for Advanced Gastroenterology  
260 Lookout Place  
Suite 201  
Maitland, FL 32751**

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_ SS#: \_\_\_\_\_  
Home Address: \_\_\_\_\_ City \_\_\_\_\_ State/Zip \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Marital Status: \_\_\_\_ Spouse's Name: \_\_\_\_\_  
Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Language: \_\_\_\_\_  
Email address: \_\_\_\_\_  
Your Pharmacy Name: \_\_\_\_\_ Zip \_\_\_\_\_ Phone: \_\_\_\_\_

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Referring Physician: \_\_\_\_\_ Phone: \_\_\_\_\_  
Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

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I authorize Center for Advanced Gastroenterology to disclose/release my health information to the following:

HIPAA Authorized Person: \_\_\_\_\_ Relation \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_  
Relationship: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

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**HEALTH INSURANCE INFORMATION:**

**Primary Insurance:** \_\_\_\_\_ Phone: \_\_\_\_\_  
Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_  
Claims Address/City/Zip: \_\_\_\_\_  
Policy Holders Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
SS#: \_\_\_\_\_ DOB: \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_ Phone: \_\_\_\_\_  
Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_  
Claims Address/City/Zip: \_\_\_\_\_  
Policy Holders Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
SS#: \_\_\_\_\_ DOB: \_\_\_\_\_

# Patient Consent

## **Acknowledgement of Notice of Privacy Practices**

The Notice of Privacy Practices is a complete description of my privacy rights as a patient of Center for Advanced Gastroenterology. By signing below, I am stating I have received Center for Advanced Gastroenterology's Notice of Privacy Practices that was also posted in the lobby.

## **Consent for Treatment/Care**

I consent to treatment and care by Center for Advanced Gastroenterology and by their physicians and health care providers. I understand that my treatment and care may include routine care, such as immunizations, and a variety of other medical services depending on my condition, such as laboratory testing.

## **Consent for Use and Release of Information**

I give permission to Center for Advanced Gastroenterology including its treating and referring providers and other staff members – to release any information about me, my health, the health services provided to me, or payment for my health services, that may be necessary: (1) for my treatment (to health care providers or facilities that need the information for my continued care); (2) for any purposes related to payment by me or a third party for services (to determine eligibility, to process an insurance claim, for utilization and quality review, or for billing of collections purposes, and necessary to obtain payment); (3) for the health care operations of the Center for Advanced Gastroenterology or another health care provider that has had a relationship with me (quality assessment, training programs, and planning).

I give permission to Center for Advanced Gastroenterology and their employees, agents and contractors to take photographs or make videos or drawings of me for permissible treatment, payment, or health care operations purposes (which may include quality assessment, education and training), as long as consistent with policies and laws that protect my rights.

## **Financial Responsibility**

I understand and agree that physician charges for medical and related professional services performed or supervised by a physician will be billed. I also understand that an insurance company may not pay the full amount of my charges, and I may be responsible (as a patient, spouse, or the parent of a minor child) for the amount not paid. If I do not have health insurance or have not provided current or accurate insurance information, I am responsible for payment of all charges.

## **Assignment of Payment**

I request that payment of authorized benefits be made to the appropriate Center for Advanced Gastroenterology on my behalf. I authorize Center for Advanced Gastroenterology to bill directly and assign the right to all health and liability insurance benefits otherwise payable to me, and I authorize direct payment to the appropriate Center for Advanced Gastroenterology.

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PATIENT SIGNATURE

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DATE

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PRINTED NAME