Center for Advanced Gastroenterology
740 S. Concourse Pkwy.
Suite 200
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.

_____ _____

PATIENT SIGNATURE DATE

_____

PRINTED NAME