

DIGESTIVE DISEASE SPECIALISTS, INC.
INSTITUTE OF DIGESTIVE DISEASE
DDSI AEC SOUTH LLC

PATIENT INFORMATION

FULL LEGAL NAME (No Nicknames)

DATE: _____

DDSI PHYSICIAN: _____

LAST NAME _____ FIRST _____ MI _____ NICKNAME _____

ADDRESS _____ CITY _____ ST _____ ZIP _____

HOME PHONE _____ CELL PHONE _____ BUSINESS NUMBER _____ EMAIL _____

(WHICH IS THE BEST NUMBER TO REACH YOU? HOME CELL)

SOCIAL SECURITY NUMBER: _____ DATE OF BIRTH _____ AGE _____

SEX (circle one) M F MARITAL STATUS Single / Married / Life Partner / Legally Separated / Divorced / Widowed / No Response

PATIENT RACE 1-Amer. Indian/Alaskan 2-Asian 3-Black/African Amer. 4-Nat. Hawaiian/Pacific Islander 5-White/Caucasian 6-Other 7-Unknown/Declined

PATIENT ETHNICITY 1-Not Hispanic or Latino 2-Hispanic or Latino 3-Declined 4-Unknown

RELIGION 1-Buddist 2-Catholic 3-Hindu 4-Islam 5-Jewish 6-Protestant 7-N/A

PRIMARY LANGUAGE 1-English 2-Spanish 3-Vietnamese 4-Decline 5-Other _____

PATIENT'S EMPLOYER _____ PATIENT'S POSITION _____

BUSINESS ADDRESS _____

SPOUSE'S NAME _____ SPOUSE'S EMPLOYER _____

SPOUSE'S WORK PHONE _____ SPOUSE'S CELL PHONE _____

PERSON RESPONSIBLE FOR BILL (IF OTHER THAN ABOVE)

NAME _____ RELATIONSHIP _____

(IF OTHER THAN ABOVE)
ADDRESS _____

HOME PHONE NUMBER _____ CELL PHONE NUMBER _____

EMPLOYER _____ POSITION _____

BUSINESS ADDRESS _____ BUSINESS PHONE _____

NEAREST RELATIVE TO NOTIFY IN AN EMERGENCY (OTHER THAN SPOUSE)

NAME _____ RELATIONSHIP _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

PREFERRED METHOD OF COMMUNICATION

HOME PHONE CELL PHONE WORK PHONE EMAIL FAX MAIL TEXT PATIENT PORTAL

PREFERRED PHARMACY

1. LOCAL PHARMACY - NAME ADDRESS, PHONE, FAX _____

2. MAIL IN PHARMACY - NAME ADDRESS, PHONE, FAX _____

INSURANCE INFORMATION (PLEASE BRING INSURANCE CARDS AT TIME OF SERVICE)

NOTICE: IF YOU'RE A CURRENT HOSPICE PATIENT PLEASE CHECK BOX

PRIMARY INSURANCE

POLICY HOLDER _____ DOB _____ SS# _____

INSURANCE COMPANY _____ GROUP# _____ POLICY# _____

INS CO ADDRESS _____ TELEPHONE# _____

POLICY HOLDER'S EMPLOYER/PHONE# _____

SECONDARY INSURANCE

POLICY HOLDER _____ DOB _____ SS# _____

INSURANCE COMPANY _____ GROUP# _____ POLICY# _____

INS CO ADDRESS _____ TELEPHONE# _____

POLICY HOLDER'S EMPLOYER/PHONE# _____

REFERRAL SOURCE

REFERRED BY (circle one) PHYSICIAN NAME _____ ; FRIEND; FAMILY; ACQUAINTED WITH DOCTOR; WITH STAFF; YELLOW PAGES; HEALTH PLAN; REFERRAL SERVICE; OTHER _____

DIGESTIVE DISEASE SPECIALISTS, INC.

NOTICE OF RECEIPT OF PRIVACY NOTICE

Patient Name (Please Print)

Date of Birth

FOR PATIENTS HAVING AN OFFICE VISIT ONLY:

Patient Initial

I have been given a copy of the Digestive Disease Specialists, Inc. (DDSI) Privacy Notice, and understand that I may request a copy of this notice at any time.

Patient Initial

I have received a copy of the Digestive Disease Specialists, Inc. Patient Rights and Responsibilities form (Form #R-0200).

FOR PATIENTS HAVING A PROCEDURE:

Patient Initial

In advance of the day of my procedure, I have been given a copy of the Digestive Disease Specialists, Inc. (DDSI) Privacy Notice, and understand that I may request a copy of this notice at any time.

Patient Initial

In advance of the day of my procedure, I have received a copy of the Digestive Disease Specialists, Inc. Patient Rights and Responsibilities form (Form #R-0200).

USE AND DISCLOSURE AGREEMENT

You have the right to restrict or limit the personal health information we disclose about you to someone else, and to specify the way in which we communicate with you about your medical issues.

Please indicate your preference below:

The following people may receive information about me:

OR

I do **NOT** want you to speak with anyone else about my health issues.

NAME	RELATIONSHIP

AUTHORIZATION TO LEAVE VOICE AND EMAIL MESSAGES

- Yes, DDSI MAY leave a message on my answering machine/voice mail regarding my Protected Health Information.
 No, DDSI MAY NOT leave a message on my answering machine/voice mail regarding my Protected Health Information.

- Yes, DDSI MAY email me a message regarding my Protected Health Information.
 No, DDSI MAY NOT email me a message regarding my Protected Health Information.

Please specify your preferred method of contact:

Phone #: _____ Email Address: _____

I understand that if I change my mind about any of the information on this form, I must contact Digestive Disease Specialists, Inc. to revoke this form in its entirety, or to complete a new form. Otherwise, this form will remain in effect for a period of two years.

Patient Signature

Today's Date

DIGESTIVE DISEASE SPECIALISTS, INC.

(Institute of Digestive Disease Specialists, Inc, DDSI South AEC, LLC, Digestive Disease Pathology, LLC)

FINANCIAL RESPONSIBILITY POLICY

In seeking medical care you obligate yourself to compensate the physician for their services. As a patient of Digestive Disease Specialists, Inc (DDSI), you are required to fill out and sign all forms prior to being seen by the physician. Failure to do so may require your appointment to be rescheduled.

Account Information...It is your responsibility to notify the office of any name, address, or phone number changes. If you are unable to keep an appointment, please notify the office as soon as possible to prevent a possible no show fee.

Insurance...You are required to provide your insurance card so that it can be scanned into our system. It is your responsibility to notify us if your insurance changes. Insurance companies have a filing deadline, so failure to provide us with the correct insurance information at the time of service may result in your being responsible for the entire bill. Please check with your insurance to determine if the doctor you are seeing is a contracted provider. All copays will be collected at the time of service. You are responsible for any deductibles, denials, etc. and agree to submit payment to DDSI immediately upon notification of responsibility from your insurance company. In the event that your insurance company denies payment for services rendered, you will be personally and fully responsible for those charges. Failure to comply can result in your account being turned to a collection agency and possible termination as a patient from the group.

Non-Insured Patients...You are expected to make payment in full on the day the service is rendered unless other arrangements have been made.

Forms of Payment...We accept Cash, Checks, Debit Cards, Visa, Master Card, American Express and Discover. There is a \$25.00 fee for all returned checks. Payment plans are available.

Work Comp...We will file your work comp claim provided that we have received authorization from your adjuster. NOTE: If you notify the clinic your injury is work related we will **not** file your health insurance.

Release of Information...I hereby authorize release of all information from DDSI. DDSI may disclose any or all of the patient’s information for insurance claim purposes. If some other party is paying the patient’s bill or by any contract may be expected to pay the bill, then DDSI may disclose any or all of the patient’s information to that party to verify charges. DDSI may disclose any or all of the patient’s information all health care providers who have a legitimate need for such information which indicates the presence of a communicable or venereal disease (such as Hepatitis, Syphilis, gonorrhea, Human Immunodeficiency Virus also known as A.I.D.S.) and/or presence of alcoholism, drug abuse and mental health problems.

I have read the Financial Policy of DDSI and agree to comply. I agree to treatment by the physician. In addition, I understand that I am financially responsible for services rendered by the physician and authorize my insurance company to pay benefits directly to the physician.

PATIENT SIGNATURE

DATE

SIGNATURE (Spouse, Guardian, Responsible Party)

DATE

Note: Photostat of the above is as valid as the original.
Revised 11/7/2011