ASSOCIATES IN DIGESTIVE HEALTH LLC

Acct # ________________

PATIENT INFORMATION

First Name **Last Name**

SSN: **DoB** **Sex** M F

Address: **Home Phone:**
Work Phone:
Cell Phone:

Email: **Referring Dr:**

Primary Care Physician: **Marital Status** Single Married Divorced Widowed

Employment: Not Employed Self-Employed Full Time Part Time Retired Military Duty

Student Status: Full Time Part Time Not (a student)

Emergency Contact Name / Phone Number:

Employer Name / Phone Number:

INSURANCE INFORMATION

Primary Insurance **Name of Policyholder:** **DoB**

Ins Carrier Name: **Subscriber's Relationship**

Ins Carrier Address and Phone:

ID Number **Group Number**

Secondary Insurance **Name of Policyholder:** **DoB**

Ins Carrier Name: **Subscriber's Relationship**

Ins Carrier Address and Phone:

ID Number **Group Number**

We ask for your response to these questions **REQUIRED BY THE STATE OF FLORIDA AND THE FEDERAL GOVERNMENT.** If nothing is circled, English and Phone will be indicated in your record.

Race: White Black/African American Asian **(CIRCLE 1 OF THESE 5 CHOICES)**
AND American Indian/Alaska Native Native Hawaiian / Other Pacific Islander

Ethnicity: Hispanic/Latino Not Hispanic/Latino **(AND CIRCLE 1 OF 2 CHOICES)**

Preferred Language: English Spanish German Other __________

Preferred Method of Communication Email or Phone or Mail

EMAIL Informed Consent I authorize Associates in Digestive Health to use my email address to send me information related to my medical care. I authorize ADH to send me articles or news releases directly related to my medical condition, including newsletters and information on related support groups. My email address is indicated above.

---I HAVE REVIEWED THE ABOVE INFORMATION AND MADE CORRECTIONS WHERE NECESSARY.---

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Patient Signature Date

ASSOCIATES IN DIGESTIVE HEALTH LLC and CAPE HEALTH SURGERY CENTER
FINANCIAL POLICY

ACCT # ______________

Thank you for choosing us to provide your medical care. We are committed to the success of your treatment. Understanding our policies regarding payment of your account is part of this process. Please read our financial policy outlined below. If you have any questions regarding this information, please ask any of our staff members for further information.

As a reminder, **it is the responsibility of each patient to know his or her own insurance benefits.** Although we do call most companies to verify coverage so that we may be able to assist you with information as to the cost of services rendered, we cannot guarantee the information that is provided to us by your insurance company. Any information we provide to you is only an estimate based on information we received from your insurance company. **We encourage you to call your insurance company with any questions you have regarding your benefits and/or the participation status of all service providers.** Thank you.

AUTHORIZATION TO FILE CLAIMS ON BEHALF OF PATIENT I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries or carriers, or to the billing agents of my insurance company, or to my employer (if this is a Worker's Compensation claim), any information needed for this or a related medical insurance claim including appeals. I permit a copy of this authorization to be used in place of the original and I request payment of medical insurance benefits be made directly to the party who accepts assignment.

PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED **We will collect your copayment, coinsurance, and any previous balance due at the time of service.** We accept cash, checks, VISA, MasterCard, American Express and Discover credit cards. Outpatient procedures will require pre-payment of your coinsurance and deductible amounts.

INSURANCE PLANS We accept Medicare assignment. We also participate with many HMO, PPO and POS insurance plans. We expend great effort to comply with the instructions and conditions of the many insurance plans; however, **it is solely the responsibility of the patient to determine whether his/her insurance plan participates with Associates in Digestive Health, Cape Health Surgery Center or with any xray, hospital, laboratory or other facilities where services may be scheduled on your behalf.** Associates in Digestive Health and Cape Health Surgery Center will assume no financial responsibility for charges incurred at facilities that are not participating with your insurance plan.

INSURANCE CLAIMS We will file claims to your insurance company for you. Eligibility and benefits are determined solely by your insurance company. You agree to pay any portion of charges not covered by your insurance company. If your insurance company requires prior authorization, precertification, or second opinion for a visit, a procedure, or a hospital admission, you are responsible to obtain this. Failure to obtain said authorizations may result in higher out-of-pocket expenses for you, the patient.

RETURNED CHECKS We charge a $20 fee for all returned checks.

PAST DUE BALANCE If your account becomes overdue, we will take any steps necessary to collect the debt. If your account is referred to a collection agency, you agree to pay all collection costs that are incurred. If legal action is required, you agree to pay all legal fees that are incurred plus court costs. In the case of a suit, you agree that the venue shall be Lee County, Florida. If your account is sent to a collection agency, referred for legal action, or is reported to a credit reporting agency, you understand that your treatment at our office may become a matter of public record.

You agree, in order for us to service your account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using pre-recorded artificial voice messages and/or use of an automatic dialing device, as applicable.

AUTO INJURY / WORKER'S COMPENSATION / PERSONAL INJURY We do not file claims to auto insurance, worker's compensation or personal injury attorneys. You must pay our services in full at the time they are rendered. Full payment of all charges remains the patient's responsibility.

My signature below indicates that I have read and understand the financial policies outlined above.

______________________________ ______________________

PATIENT SIGNATURE DATE

ASSOCIATES IN DIGESTIVE HEALTH

Acct # ____________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been given the opportunity to review this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document. I also understand that uses and disclosures may be permitted without prior consent in the event of an emergency.

If it is necessary for the physicians or staff of Associates in Digestive Health to notify me of personal health information or to obtain information related to my care, I understand that I may be contacted at any of the telephone numbers I provide unless specifically stated differently on the line below.

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Protected health information **MAY BE** left on my voice mail at this number: ______________
(Your preferred phone number will be used if left blank.)

Associates in Digestive Health may speak to / release information to the following family members/friends about my Personal Health or Financial information: **LIST NAMES BELOW.**

____________________ ____________________ ____________________

____________________ ____________________ ____________________

We may change our policies and this notice at any time and have those revised policies apply to all the protected information we maintain. If or when we change our notice, we will post the new notice in the office where it can be seen.

______________________________________ ______________________
Signature of Patient or Personal Representative Date

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Print Name

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Relationship to Patient

FOR PRACTICE USE ONLY:
Associates in Digestive Health made the following good faith efforts to obtain the above-referenced individual's written acknowledgement of receipt of the Notice of Privacy Practices.

[Identify the efforts that were made to obtain the individual's written acknowledgement, including the reasons (if known) why the written acknowledgement was not obtained.]

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Staff Signature: ______________________________ Date: ____________________

Patient Name ______________________________

Date of Birth ______________________________

Revised 01/15