CONFIDENTIAL PATIENT INFORMATION

DEMOGRAPHICS

Last Name _____ First Name _____ Middle _____ Previous Last Name _____

Preferred Name to be called _____ Social Security _____-_____-_____ Birth Date _____/_____/_____ Sex _____

Mailing Address _____ Appt/Lot/Space # _____ Zip Code _____

Race (**Select one or more**)
- ☐ White
- ☐ Hispanic or Latino
- ☐ Black or African American
- ☐ Asian
- ☐ American Indian / Alaska native
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Unknown / Not reported

Preferred Language _____

Ethnicity
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Unknown /Not Reported

Preferred Method of Contact to Receive Health Care Reminders (**Select one**)

☐Cell /☐Home /☐Work /☐Mail /☐Patient Portal

Marital Status (**Select One**) ☐Married /☐Partner /☐Separated /☐Divorced /☐Single /☐Widow

Primary Care Physician (First and Last Name) _____

Referring Physician (First and Last Name) _____

Your Home Telephone _____ Your Work Telephone _____

Your Cell Telephone _____ Your E-Mail Address _____

Employment Status (**Select One**) ☐Part-time /☐Full-time /☐Retired /☐Other

Company Name _____Telephone_____ Job Title_____

Name of Your Emergency Contact _____ Relationship _____ Telephone _____

INSURANCE **Please bring all of your insurance cards for each visit.**

Primary Insurance _____

Name as it appears on card _____ Policy Holder's Birth Date _____

Policy Number _____ Group Number _____ Effective Date _____

Secondary Insurance _____

Name as it appears on card _____ Policy Holder's Birth Date _____

Policy Number _____ Group Number _____ Effective Date _____

Tertiary Insurance _____

Name as it appears on card _____ Policy Holder's Birth Date _____

Policy Number _____ Group Number _____ Effective Date _____

General Consent

The information presented here enables you to consent for needed medical care services, as well as for the release of information from your medical records for medical and administrative purposes.

CONSENT FOR TREATMENT: I am presenting myself for outpatient care at Digestive Health Clinic, LLC and I voluntarily consent to the rendering of such care including diagnostic procedures and medical treatment by authorized agents and employees of Digestive Health Clinic, LLC and by medical staff or their designees as in their professional judgment may be deemed necessary. I acknowledge that no guarantees have been made to me as to the result of examination or treatment in this Clinic.

ASSIGNMENT OF BENEFITS/PAYMENT AGREEMENT: I hereby authorize payment directly to Digestive Health Clinic, LLC of all healthcare benefits, not to exceed charges, to which I would otherwise be entitled for these services. **IT IS YOUR RESPONSIBILITY TO TELL US IN ADVANCE IF THERE ARE ANY SPECIAL REQUIREMENTS FOR YOUR INSURANCE/THIRD PARTY PAYER, e.g., PRE-AUTHORIZATION OF PROCEDURES OR HOSPITAL ADMISSIONS.**

CONSENT TO RECEIVE E-MAIL AND TEXT COMMUNICATIONS: By providing my e-mail or telephone number, I agree the Digestive Health Clinic may contact me by e-mail or text. I understand that an e-mail to text may not be secure and there is some risk that it may be read by third parties.

CONSENT TO RECEIVE NON-HEALTHCARE PRERECORDED MESSAGES: To the extent consent is required by the Telephone Consumer Protection Act ("TCPA"), I hereby authorize the Digestive Health Clinic and its designees to deliver messages containing non-health care communications (e.g., patient satisfaction surveys, account calls, etc.) through the use of an automatic telephone dialing system or artificial or prerecorded voice messages. I am not required to agree to receive such communications and my agreement is not a condition of receiving items or services from the Digestive Health Clinic. Notwithstanding the foregoing, the Digestive Health Clinic does not waive and expressly reserves the right to contact me by any means for any purpose as otherwise permitted by law. By signing below, I have consented to receive non-healthcare prerecorded communications to the telephone number I have provided on the front of this page.

PERSONAL VALUABLES: It is understood and agreed that Digestive Health Clinic, LLC shall not be liable for the loss of or damage to any money, jewelry, documents, fur garments, or other articles of unusual value. It is also understood that I must bring any required documents, insurance cards and payments requested by Digestive Health Clinic, LLC.

HIPAA ACKNOWLEDGMENT: My signature below acknowledges that the Digestive Health Clinic, LLC Notice of Privacy Practices (NPP) has been made available to me on this date or on a previous date; it does not indicate that I agree to the terms of NPP.

Office use only: Patient declined or is unable to sign for receipt of the NPP: _____

I CERTIFY THAT I HAVE READ AND UNDERSTAND THIS FORM AND DO VOLUNTARILY AGREE TO ITS PROVISIONS.

_____ _____

Patient Signature Date/Time

_____ _____

Responsible Person Relationship

MEDICARE PATIENT'S ASSIGNMENT AUTHORIZATION (For Medicare insured patients only)

I request that payment of authorized Medicare benefits be made on my behalf to Digestive Health Clinic, LLC for any services furnished to me by a provider of the group. I authorize any holder of medical information about me to be released to Medicare and Medicaid Services and its agents any information needed to determine these benefits or benefits for related services payable. In Medicare assigned cases, the provider agrees to accept the charge determination of the Medicare carrier and I am responsible for the Medicare deductible, co-insurance or the 20% that Medicare does not pay, and for any non-covered services. My signature below further verifies that I have not joined an HMO or other entity in which my Medicare benefits have been relinquished.

_____ _____ _____

Signature Date Medicare Number

MEDIGAP OR OTHER SECONDARY INSURANCE AUTHRORIZATION (For Medicare insured patients who also have a secondary insurance)

I request that payment of authorized Medigap benefits be made either to me or on my behalf to Digestive Health Clinic, LLC for services provided to me by a physician/provider/supplier. I authorize any holder of medical information about me to be released to my Medigap insurer or any information needed to determine these benefits or the benefits payable for related services.

The assignment shall remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original.

_____ _____

Name of Medigap insurer or secondary insurance carrier Medicare Number

_____ _____

Signature Date