Confidential Patient Information

PATIENT INFORMATION

NAME (Last, First Middle)				PREFERRED NAME
ADDRESS CITY, STATE, ZIP				APT TRLR SPACE
SSN	BIRTH DATE	SEX	GENDER IDENTITY	MARITAL STATUS
RACE	ETHNICITY	LANGUAGE	E-MAIL	
HOME PHONE	CELL PHONE	DAY PHONE		

PREFERRED CONTACT CELL PHONE DAY / WORK PHONE HOME PHONE E-MAIL	NOTIFICATION OPT OUT E-MAIL SMS(Text) VOICE REMINDERS
PRIMARY EMPLOYER	EMERGENCY CONTACT
EMPLOYMENT STATUS PART - TIME FULL - TIME RETIRED OTHER	RELATIONSHIP
OCCUPATION	HOME PHONE / WORK PHONE / CELL PHONE
WORK PHONE	SUPPORT ROLE Emergency Contact Next of Kin Caregiver
NAME OF PHARMACY	PHARMACY PHONE NUMBER
PHARMACY ADDRESS	PHARMACY CITY

PRIMARY / REFERRING PHYSICIAN INFORMATION

PRIMARY CARE PHYSICIAN	REFERRING PHYSICIAN

PRIMARY INSURANCE		SECONDARY INSURANCE	
NAME OF THE INSURANCE COMPANY		NAME OF INSURANCE COMPANY	
POLICY #	GROUP #	POLICY #	GROUP #
POLICY HOLDER NAME		POLICY HOLDER NAME	
POLICY HOLDER BIRTHDATE		POLICY HOLDER BIRTH DATE	
EFFECTIVE DATE		EFFECTIVE DATE	

SELF PAY PATIENT

GENERAL CONSENT

Assignment of Benefits/Payment Agreement: I am eligible for the insurance indicated on this form and I hereby authorize payment directly to Digestive Health Clinic, LLC (DHC) dba Nampa Digestive Health Clinic (NDHC) and/or Idaho Endoscopy Center, LLC (IEC), dba Nampa Idaho Endoscopy Center (NIEC). I understand that it is my responsibility to let DHC/NDHC, and/or IEC/NIEC know if there are any special requirements for my insurance and/or third-party payer. If I have Medicare or any Insurance plan linked to Medicare, I request that payment of the authorized Medicare benefits be made on my behalf to DHC/NDHC and/or IEC/NIEC 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/Medicaid/Medigap and any other insurer and its agents to determine these benefits as payable. In Medicare and all other insured assigned cases, the provider agrees to accept the charge determination of the insurance carrier and I am responsible for the deductible, coinsurance, or for any non-covered services. The assignment shall remain in effect until revoked by me in writing.

_____ _____

SIGNATURE OF PATIENT/GUARDIAN DATE

CONSENT FOR TREATMENT

I am presenting myself for outpatient care at to Digestive Health Clinic, LLC (DHC) dba Nampa Digestive Health Clinic (NDHC) and/or Idaho Endoscopy Center, LLC (IEC), dba Nampa Idaho Endoscopy Center (NIEC). I voluntarily consent to the rendering of such care including diagnostic procedures and medical treatment by authorized agents and employees of DHC and IEC and their medical staff or their designees, as in their professional judgement, deemed necessary. I acknowledge that no guarantees have been made to me as to the result of examination or treatment in this clinic.

HIPAA ACKNOWLEDGEMENT

I acknowledge that to Digestive Health Clinic, LLC (DHC) dba Nampa Digestive Health Clinic (NDHC) and/or Idaho Endoscopy Center, LLC (IEC), dba Nampa Idaho Endoscopy Center (NIEC). Notice of Privacy Practices (NPP) has been made available to me on this day or on a previous date; by signing below, it does not indicate that I agree to the terms of the NPP.

COMMUNICATION CONSENT

By providing my e-mail or telephone number, I agree that Digestive Health Clinic, LLC (DHC) dba Nampa Digestive Health Clinic (NDHC) and/or Idaho Endoscopy Center, LLC (IEC), dba Nampa Idaho Endoscopy Center (NIEC) 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.

To the extent consent is required by the Telephone Consumer Protection Act ("TCPA"), I hereby authorize delivery of messages containing non-health care communications (e.g. patient satisfaction surveys, account calls, etc.) through the use of an automatic/artificial telephone dialing system, pre-recorded voice messages or e-mail. I am not required to agree to receive such communications and my agreement is not a condition of receiving items or services. Notwithstanding the foregoing, the Company does not waive and expressly reserves the right to contact me by any means for any purposes as otherwise permitted by law. By signing below, I have consented to receive e-mails or non-healthcare pre-recorded communications to the e-mail address or telephone number I have provided.

PATIENT NOTICES

Please take a moment to review the following Patient Notices which have been made available to you on our website at **www.digestivehealthclinic.com** and will be available to you in printed form upon check-in. It is your responsibility to know and understand these forms.

Patient Notice Acknowledgment:
By signing below, I acknowledge that on or before this day, the following information was made available to me;

1. Notice of Privacy Practice
2. Notice of Patient Rights and Responsibilities – this notice shall be provided in verbal format upon check-in
3. Notice of Advanced Directives Policy & Living Will resources in the State of Idaho
4. Notice of Ownership
5. Notice of Non-Discrimination & Accessibility
6. Agreement of Financial Responsibility *including* Notice of Cancelation and No-Show Policy
7. Colonoscopy – What you need to know!

I have read, understand, and agree to the above information and by signing this document I acknowledge receipt of this information. I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

SIGNATURE OF PATIENT/GUARDIAN _____ DATE _____