

CONFIDENTIAL PATIENT INFORMATION

DEMOGRAPHICS

Last Name First Name Middle Previous Last Name

Preferred Name to be called Social Security Birth Date Gender (Circle One) Male / Female

Mailing Address Appt/Lot/Space # Zip Code

Race (Select one or more) Preferred Language Ethnicity
White Hispanic or Latino Black or African American Asian American Indian / Alaska native Native Hawaiian or Other Pacific Islander Unknown / Not reported
Hispanic or Latino Not Hispanic or Latino Unknown / Not Reported
Preferred Method of Contact (Circle One) Cell / Home / Work / Mail / E-mail

Marital Status (Circle One) Single / Married / Widowed / Divorced / Separated

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

Name of Your Emergency Contact Relationship Telephone

Employment Status (Circle One) Part-time / Full-time / Retired / Other
Company Name Telephone Job Title

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

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.

ASSIGNMENT OF BENEFITS/PAYMENT AGREEMENT: All accounts are due and payable at the time of visit unless other prior arrangements have been made. I understand that I am responsible for any and all balances owing. 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. I understand and agree regardless of my personal ability to pay, that I am financially responsible to Digestive Health Clinic, LLC for charges not covered by third party payer.

Date Patient or Responsible Party Signature

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.

HIPAA ACKNOWLEDGMENT: I hereby acknowledge that I have received a copy of the Digestive Health Clinic, LLC Notice of Privacy Practices on this date or on a previous date. **Initial** _____

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.

RELEASE OF INFORMATION: I authorize Digestive Health Clinic, LLC to release to the third party payer named in my registration, or a designated review agency, any information from my medical record, including information about my treatment, which is needed for the purpose of processing my claim. I also authorize Digestive Health Clinic, LLC to release to a referring physician information about my treatment and progress.

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 the Digestive Health Clinic, LLC.

IDAHO ENDOSCOPY CENTER, LLC: It is understood that Idaho Endoscopy Center, LLC is owned by, and operated as a part of the practice of, the providers of Digestive Health Clinic, LLC. I understand that I may choose to have certain gastroenterology or endoscopic procedures done at Idaho Endoscopy Center or at either St. Lukes Regional Medical Center or St. Alphonsus Regional Medical Centers.

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 their physicians. I authorize any holder of medical information about me to be released to the Centers for Medicare and Medicaid Services and its agents to determine these benefits or the benefits payable for related services.

Date _____ Signature _____

MEDIGAP SIGNATURE ON FILE (For Medicare insured patients who have a secondary insurance only)

I request that payment of authorized Medigap benefits be made on my behalf to Digestive Health Clinic, LLC for any services furnished to me by their physicians. I authorize any holder of medical information about me to be released to

_____ (Name of Medigap insurer/secondary insurance carrier) to determine benefits.

Date _____ Signature _____

Name of Patient

Medicare Claim Number

Medigap Policy

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

Patient Signature _____ Date/Time _____

Responsible Person _____ Relationship _____ Witness _____