Patient General Info

*Thank you for choosing us to be your
Center for excellent Gastrointestinal care!*

Athens Gastroenterology Center, PC
Athens Endoscopy, LLC

GREGORY S. SMITH, M.D.
Board Certified Gastroenterology & Hepatology

Patient Demographics:

Patient Full Name: _____ **Previous Name/Nickname:** _____

Mailing Address: _____ **City:** _____ **State:** ____ **Zip:** _____
Social Security #: _____ **Mark box if Billing Address same as Mailing:** ☐ **or if not the same➔**
Billing Address: _____ **City:** _____ **State:** ____ **Zip:** _____
E-Mail address: *(case sensitive)*: _____ **or mark box if NO e-mail➔** ☐

Best time to call: AM ☐ **or** PM ☐. **SPECIAL NEEDS when calling:** *circle➔* Relay/Speak Loud/Speak Slow
Home Phone: _____ **➔ OK to leave a message at home number?** Yes ___ or No ___
Cell Phone: _____ **➔ OK to leave a message at cell number?** Yes ___ or No ___
Work Phone: _____ **➔ OK to leave a message at work number?** Yes ___ or No ___

Primary Care Physician: _____ **Referring Physician:** _____

Emergency contact will **only be contacted in emergencies. If you want us to discuss medical info with this person, please also list them on the backside for disclosures.**

Emergency contact: _____ **Cell:** _____ **Home/Work:** _____

The following information is necessary for healthcare purposes and is NOT used in any way to discriminate. Each of these factors do have an effect on each patient's level of stress and/or health: employment, social status, age, sex, genetics (including genes of certain races and each gender.)

Marital Status: _____ **Sex:** *circle➔* Male/ Female/ Transgender from female/ Transgender from Male
Date of Birth: _____ **Race:** _____ **Are you Hispanic or Latin?:***(check one)* Yes ___ **or** No ___

Employment: *circle➔* Retired/ Self-Employed/ Not Employed/ Employed Full-Time/ Employed Part-Time
Employer Name: _____ **Phone:** _____
Employer Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Insurance Information: *(*Must present ID and insurance cards to Office Staff.)*

Primary Insurance: _____ **Secondary Insurance:** _____

It is the responsibility of the patient to know what physicians, hospitals, radiology, laboratories, and facilities are in network with his/her current insurance coverage. Please check with your insurance prior to going to any physician, radiology, laboratory, facility or hospital.

Select Hospital: *circle one➔* Athens Regional / St. Mary's / Athens Endo, LLC / Either
Preferred X-Ray Facility: _____ **Preferred Lab Facility:** _____
Preferred Pharmacy: _____ **Address:** _____ **Phone:** _____

**If Insurance is not under patient's name, please fill out the following information about the subscriber:*
Subscriber Name: _____ **Relationship:** _____ **Date of birth:** _____

Patient Agreement:

I hereby authorize payment of medical benefits billed to my insurance to Athens Gastroenterology Center, P.C. (AGC)/Gregory S. Smith, M.D. ***I hereby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance.*** *I also accept responsibility for fees that exceed the payment made by my insurance, if the Practice* ***does not*** *participate with my insurance. AGC is not responsible for knowing my contracted insurance.* ***I agree to pay all copayments, if any, at the time the service is rendered.*** *I understand that this practice accepts cash, personal checks, money orders, most major credit cards and debit cards. If I do* ***not have insurance****,* ***I agree to pay all charges/fees*** *for services rendered at the time of service.*

By signing, I am verifying that the information is accurate:
Patient or Guardian Signature_____ **Date:** _____

Please, fill out front and back.

PATIENT CONSENT and HIPAA FORMS

GREGORY S. SMITH, M.D.
Board Certified Gastroenterology & Hepatology

NOTICE OF PRIVACY POLICY: I understand that I may review the revised practice Privacy Policy online at www.athensgicenter.com, or as posted in the lobby and at my request I may receive a copy.

FINANCIAL RESPONSIBILITY and ASSIGNMENT OF BENEFITS: I, the undersigned certify that I (or my dependent) have insurance coverage as listed on previous page. I hereby authorize payment of medical benefits, billed to my insurance, to Athens Gastroenterology Center P.C./Gregory S. Smith, M.D. I understand that Athens Gastroenterology Center, P.C. will file my insurance as a courtesy to me and that I remain financially responsible for payment of co-pays, deductibles, non-covered services, and any other charges not paid by my insurance within 30 days. I hereby authorize Athens Gastroenterology Center P.C. to release all information necessary to secure payment of benefits. I authorize the use of this signature for checking all insurance eligibility, for insurance claims, and for checking Rx eligibility. I understand that Athens Gastroenterology Center, P.C. is not responsible for knowing what my insurance covers. We require a notice of at least 48 hours if you need to cancel or reschedule appointments. As we try to accommodate our patient's needs when scheduling, we may be able to offer your appointment to another patient. If no notice is given to cancel/ reschedule then we are not able to offer the appointment to other patients who may need it. For this reason, after two missed appointments without notice to cancel/ reschedule, our policy is to consider discharging your care from our practice. A $50 fee will be charged for appointments not canceled 48 hours prior to appointment or if you NO SHOW.

MEDICAL LIFETIME SIGNATURE ON FILE *(IF APPLICABLE)**:*** I request that payments of authorized Medicare benefits be made to Athens Gastroenterology Center P.C./Gregory S. Smith, M.D. for any service(s) furnished. I authorize any holder of medical information about me to release to the Health Care Finance Administration and its agent any information needed to determine these benefits payable for related services.

CONSENT FOR TREATMENT AND COMMUNICATION: Having voluntarily presented myself (or my dependent) I acknowledge recognition of the fact that the evaluation and treatment received, advised or deemed necessary, to be the judgment of the AGC Medical Providers.

I give Athens Gastroenterology Center P.C. & third party companies permission to contact me by phone, sending me text messages, e-mails, pre-recorded/ artificial voice messages, and/ or pre-recorded automatic dialing device, as applicable at the phone numbers I have provided for health care correspondence and billing purposes.

For health care correspondence, mark the box to *opt out* of: **text messages** **e-mails** **voice messages**

RELEASE OF INFORMATION AUTHORIZATION: I authorize the release of all of my previous and current medical records from other physicians, or medical facilities **to** Athens Gastroenterology Center, P.C., including my history of pharmaceutical drugs, human immunodeficiency virus, psychiatric, drug/alcohol abuse records, venereal disease, and any other statutory protected disease, in order to obtain insurance reimbursement, or to comply with utilization review, or as necessary for continued medical care for as long as I am under the care of AGC's Medical Providers.

I hereby authorize Athens Gastroenterology Center, P.C. to use or disclose my health information which specifically identifies me/my condition or which can reasonably be used to identify me to carry out my treatment, payment, and health care operations.

Athens Gastroenterology Center P.C. values and does everything in its power to protect the patient's privacy. My **medical information will not be given** to *any* individual (*including* spouses, parents, children, or any significant others) **without my written consent or without presenting a Power of Attorney**. **If I want anyone to have access to my medical information, I will list their name below. Their date of birth is used as an access code for us to discuss information with them**. This disclosure does NOT apply to the emergency contact listed on page one if they are not listed below. I understand that uses and disclosures may be permitted without prior consent. To obtain copies of my medical records, I understand I must sign a Release of Medical Information form (apart from this form) and the Practice may apply a fee.

Name of Relative/Friend we can discuss your Medical Info:

Name:	Relation:	Phone:	Their Date of Birth:

By signing, I confirm that I am in agreement; authorizing all of the above:

Patient or Guardian Signature_____ **Date:** _____

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Give forms to Front Office Staff