Patient General Info

Consent to Treatment & Responsibility; HIPAA & Disclosure

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

DEMOGRAPHIC INFO:

Patient Full Name: _____ **Date of Birth:** _____

Pre-Fix: [] Mr. [] Ms. [] Dr. [] Other: **Suffix:** [] Sr. [] Jr. [] III [] MD [] Other: **Birth Sex:** [] M [] F

Previous Name/Nickname: _____ **Current Sex:** *If not the same as birth sex* [] Transgender from female

Race: *(if multi-racial, list both)* _____ [] Transgender from Male

Hispanic/ Latin?: [] yes [] no **Marital Status:** «MaritalStatus» **Social Security Number: ***

CONTACT METHOD:	CONTACT INFO:	BEST TIME TO CALL:	OK TO CONTACT BY:
Home Phone:		* [] AM [] PM	* [] Call [] Voicemail
Cell Phone:	[] NO cell	* [] AM [] PM	* [] Call [] Voicemail [] Text
Work Phone:		* [] AM [] PM	* [] Call [] Urgent Calls ONLY
E-mail: *(case sensitive)*			* [] Patient Portal Updates [] NO e-mail

SPECIAL NEEDS when calling: [] Relay [] Speak Loud [] Speak Slow [] Call my emergency contact for all communication

Mailing Address/City/State/Zip: _____ [] Live here Seasonally (see alternate address)

[] Live here ALL Year [] Send Bills here

Alternate Mailing or Billing Address/City/State/Zip: _____ [] N/A [] Send Bills here

[] I do not have a Residential Address at this time

This 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.)

INSURANCE & EMPLOYER INFO:

[] NO insurance/Self-Pay [] I did NOT bring my insurance cards

[] My Insurance requires a referral authorization

Guarantor/ Responsibility: [] Self [] Spouse [] Parent [] Other:

Primary Insurance: _____ **Member ID:** _____

Secondary Insurance: _____ **Member ID:** _____

Tertiary Insurance: _____ **Member ID:** _____

Subscriber Name: _____ **Their Date of Birth:** _____

Relationship: [] Self [] Spouse [] Parent [] Other: **Patient Employer:** [] N/A

Employment Status: [] Employed Full-Time [] Part-Time [] Self-Employed [] Not Employed [] Disability [] Retired [] Student

Employer Address/City/ State/ Zip: _____ [] N/A

If the Insurance is not under the patient's name, please fill out the Subscriber Name, Date of Birth, and Relationship.
Please present your ID and insurance cards to Office Staff.

CARE TEAM NAME & PHONE:

TITLE:	NAME:	PHONE:
Emergency Contact *relative/friend*:		
Care Taker, if applicable:	[] N/A	
Primary Care Physician:	«PcpFName» «PcpMInitial» «PcpLName» «PcpSuffix»	
Referring Physician:	«RefPrFName» «RefPrMInitial» «RefPrLName» «RefPrSuffix»	

*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.*

PREFERRED FACILITIES:

Facility for Lab Tests: _____ **Facility for Radiology Tests:** _____

Facility for Procedures: [] Athens Endoscopy, LLC [] St. Mary's [] Piedmont Athens Regional [] Either

Pharmacy & Phone: _____ _____

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.

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

PATIENT RESPONSIBILITY, CONSENT TO TREATMENT, PAYMENT & HIPAA AUTHORIZATION

Patient Full Name:		Date of Birth:	

NOTICE OF NOTICE OF PRIVACY POLICY: I understand that I may review the current 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) hereby **accept responsibility and agree to pay all charges/ fees for service(s) rendered (at the time of service) that is not covered by my insurance; exceeds the payment made by my insurance; if the Practice does not participate with my insurance; or if I do not have insurance or otherwise choose Self-Pay instead of filing my insurance.** I verify I have insurance coverage as stated on page 1 unless otherwise stated also on page 1. I understand it is MY responsibility to keep AGC updated with my current personal information and current insurance information and I am aware it is NOT the responsibility of Athens Gastroenterology Center P.C. and its staff/ medical providers to know the details of my current contracted insurance and what it covers. I hereby authorize payment of medical benefits, billed to my (or my dependent's) insurance, to Athens Gastroenterology Center P.C./ Gregory S. Smith, M.D. I understand that Athens Gastroenterology Center, P.C. will file my (or my dependent's insurance *as a courtesy* to me and I agree that I remain financially responsible for payment of co-pays/co-insurance and unmet deductibles and/or due balance (DUE AT TIME OF VISIT), non-covered services, and any other charges not paid by my (or my dependent's) insurance within 30 days. **I hereby authorize Athens Gastroenterology Center P.C. to release all of my (or my dependent's) 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 Athens Gastroenterology Center, P.C. requires a prior notice of at least 48 business hours if I need to cancel or reschedule a clinic appointment so they may offer my appointment to another patient who needs it. If little or no notice is given to cancel/ reschedule then there is insufficient time to offer my (or my dependent's) appointment to other patients who need it. For this reason, after two missed appointments without notice to cancel/ reschedule, I understand it is the policy of Athens Gastroenterology Center, P.C. to consider dismissing my care from their practice. I authorize for Athens Gastroenterology Center, P.C. to charge a $50 fee, for which I will be responsible to pay, for short-notice cancelations of appointment or if I NO SHOW. I understand that this practice accepts cash, personal checks, money orders, most major credit cards and debit cards.

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 (or my dependent) 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 professional judgment of the AGC Physician and Allied Health Professionals. I give authorization to Athens Gastroenterology Center P.C. to evaluate and provide treatment to me (or my dependent). I give Athens Gastroenterology Center P.C. & third party companies permission to contact me by phone, TeleHealth video call consult, telephone consult, 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, check the box to *opt out* of: [] text messages [] e-mails [] voice messages

RELEASE OF INFORMATION AUTHORIZATION: **I hereby 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 (or my dependent's) 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 (or my dependent) am under the care of AGC's Medical Providers**. **I hereby authorize Athens Gastroenterology Center, P.C. to use or disclose my (or my dependent's) health information** which specifically identifies me/my (or my dependent's) condition or which can reasonably be used to identify me (or my dependent) 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 (or my dependent's) **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 Medical Power of Attorney or Court Order**. **If I want anyone to have access to my (or my dependent's) 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 an Authorization to Release of Medical Information form (apart from this form) specifying what records are to be released and to whom.

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Name of Relative/Friend we can discuss your Medical Info: **[] check box for NO disclosure to relatives/friends**

NAME:	RELATION:	PHONE:	THEIR DATE OF BIRTH

By signing, I am verifying the information I have provided on page 1 is correct to the best of my knowledge. By signing I also confirm I understand; am in agreement with; and authorize all of the above.

*****Patient/ Guardian Signature:** _____ **Date:** _____

PLEASE COMPLETE BOTH SIDES