

CONSULTANTS IN GASTROENTEROLOGY

Please complete this form in its entirety and bring to your appointment. Thank you.

Name: _____ Date: _____
(First) (Middle) (Last)

Address: _____
(Street) (P O Box)

(City) (State) (Zip) (County)

Telephone: (Home) _____ (Business) _____ (Cell) _____

Social Security #: _____ Driver's License #: _____

Age: _____ Date of Birth: _____ Sex: _____ Allergies: _____

Employer: _____ Address: _____

Marital Status: _____ Insured's Name: _____

Insured's Social Security #: _____ Insured's Business Phone #: _____

Insured's Employer: _____

Insured's Date of Birth: _____ Relationship: _____

Person to Contact in Case of Emergency: _____ Phone #: _____

Relationship: _____ Name of Referring Physician: _____

INSURANCE INFORMATION: It is the Patient's Responsibility to Notify the Insurance Company prior to Admission if Precertification is necessary.

Primary Insurance Company: _____ Policy #: _____

Address and Phone # to send claim: _____

Name of Policy Holder and Relationship: _____

Secondary Insurance Company: _____ Policy # _____

Address and Phone # to send claim: _____

Name of Policy Holder and Relationship: _____

I Certify that all of the above information is correct.

(Patient's Signature or Responsible Party)

PLEASE LET THE RECEPTIONIST MAKE A COPY OF YOUR INSURANCE CARD. THANK YOU

DESIGNATION OF CARE PROVIDERS FOR COMMUNICATION OF PROTECTED HEALTH INFORMATION

Patient Name: _____

Physician: _____ Birthdate: _____

Address: _____

Phone Number: (H) _____ (W) _____

I hereby request that my protected health information be communicated with others directly involved in my care. This designation of care providers will be kept as a permanent part of my medical record and will be copied as required in order to allow communication of my protected health information. I understand that my health care providers will use judgment in determining the minimum amount of information that must be shared in order to care for me.

I will inform my designated care providers of the last four digits of my social security number for identification purposes when inquiring about my health information.

DESIGNATION OF CARE PROVIDERS: (Specify name, relationship, agency, healthcare provider, etc. that will be allowed information as needed for your treatment)

Signature: _____ Date: _____
Patient

(copy to patient)

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I understand that as part of my healthcare, Consultants in Gastroenterology, South Carolina Endoscopy Center, and South Carolina Endoscopy Center – Northeast, originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Privacy Practices that provide a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices. I understand that I have the right to request restrictions to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information. (Specify agency, healthcare provider, etc. that will be restricted information, expiration of the request, type of information, reason for restriction, etc.)

Signature of Patient or Legal Representative

Witness

Date

Patient Financial Policy

Consultants in Gastroenterology and the South Carolina Endoscopy Centers are committed to providing the highest quality of care. The cost of care is expensive and a financial policy is a part of every medical practice.

Patient Responsibility:

Patients are ultimately responsible for all charges for services provided by Consultants in Gastroenterology and the South Carolina Endoscopy Center and payment is due when services are rendered. If a procedure is scheduled, a non-refundable deposit may be required. This deposit will be applied to any deductible or co-pay that needs to be met.

We do have the right to deny treatment that is determined a non-emergency by our physicians for any outstanding balance with either Consultants in Gastroenterology or the South Carolina Endoscopy Center.

We do accept payments by Cash, Personal Check, Debit Card, Visa, Mastercard, and American Express.

Insured Patients:

As a courtesy to you, we will file your primary and secondary insurance. **If we do not participate** with your insurance company, any unpaid balance following insurance payment is your responsibility. **If we do participate** with your insurance, any amount due after the applicable contractual adjustment will be your responsibility.

Please provide us with updated and current information needed to file your claim. If this is not obtained on the date service is rendered you may be responsible for your bill. You are also responsible for notifying us of any changes in insurance. A copy of your card is required at every visit. If you do not have your card at the time of visit you will be asked to sign a waiver, and may be billed for the services.

To find out if we participate with your insurance please call 803-939-4100. Different insurance companies have different co-pays and deductibles. Please be aware of your individual policy requirements. You are required to pay your co-pay and/or deductible at the time of your visit.

We do participate with **Medicare**, and file insurance secondary to Medicare. It is your responsibility to pay your co-insurance and/or deductible at the time of service.

We are also a participating provider for South Carolina **Medicaid** however, you must have your current card at the time of service. Your card must have remaining visits left to be valid. **Please note that we do not accept managed care / HMO Medicaid.**

It is the patient's responsibility to provide us with the primary care physician referral form. Check to see if your insurance requires a referral, and verify that it is obtained before your visit. If a referral is required, but not obtained then full payment will be required from the patient at the time of service.

If your insurance carrier has not paid your claim in full within 60 days, you will be contacted regarding payment, and may be responsible for the bill.

Non-insured Patients:

All non-insured patients are required to call 803-939-4100 ext 150 or 169 prior to their visit to make payment arrangements. There are special discounts for prompt payment for self-pay patients, so please call to receive more information. If arrangements are not made prior to the visit, payment in full is expected at the time of service.

Workman's Compensation:

Please be aware that we do **not** file workman's compensation.

Returned Checks:

You will be charged a \$30.00 fee in the event that your check is returned for any reason.

Cancellations and No Shows:

An appointment is considered a cancellation when there is **more than** 24 hours notice given. When a patient fails to show for an appointment, or gives less than 24 hours notice to cancel an appointment, this is considered a "no show". Patients are allowed one "no show" per calendar year. A \$25.00 charge for any additional "no show" will be added to the patient account balance.

Collections:

We reserve the right to send accounts with balances over 60 days old to an outside collection agency. The agency does have the right to report the past-due balance to the credit bureau. If your account is sent to collections you will be charged a \$10.00 collections processing fee.

If you have any questions please call 803-939-4100.

I have acknowledged and read the above policy regarding my financial responsibility to Consultants in Gastroenterology and/or the South Carolina Endoscopy Center.

Patient Name(print): _____ **Date of Birth** _____

Patient Signature

Date