DIGESTIVE DISEASE CONSULTANTS, LTD

Date Completed: **Patient Demographic form**

Patient Name ____
Last Name First Name Middle Name Maiden Name

Address ____
Street City and State Zip Code

School address if Student: ____
Street City and State Zip Code

Home Ph # ____________ Cell Ph # ____________ Work Ph # ____________

Preferred Ph: (circle one) Home Cell Birth Date ____________ Age ______

Male / Female Martial Status S M W D SS# ________ - ________ - ________

E-mail Address: ______________________ Please send invite to patient portal YES or NO

Employed by ______________________ Occupation ______________________

Spouse's Name ______________________ Spouse's Ph # ______________________

Primary Physician ______________________ Referring Physician ______________________

Local Pharmacy Name & Location ____

Mail in Pharmacy name & address (please provide copy of pharmacy card) ______________________

If patient is a minor, please complete this section

Guarantor Name ____
Last Name First Name Middle Name

Address ____
Street City and State Zip Code

Home Phone ____________ Work Phone ____________ Cell Phone ____________

Relationship to patient ____

PRIMARY INSURANCE COVERAGE	**SECONDARY INSURANCE COVERAGE**
Name of Policy Holder ______________________	Name of Policy Holder ______________________
Relationship to Patient ______________________	Relationship to patient ______________________
Insurance Company ______________________	Insurance Company ______________________
Policy Holder's Birth Date ______________________	Policy Holder's Birth Date ______________________
Insured's SS# ______________________	Insured's SS# ______________________
Account # /Group # ______________________	Account # /Group # ______________________
ID # ______________________	ID # ______________________

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PATIENT NAME:_______________________________________DOB:______________MR#:_____________

PT EMAIL ADDRESS:____

PBM Consent Yes________ No________ (Prescription Benefit Manager-allows DDC to view medication history prescribed by other physicians)

FINANCIAL POLICY

I hereby authorize payment of medical benefits directly to Digestive Disease Consultant, LTD for services rendered. Authorization is hereby granted to release information contained in my medical records as may be necessary to process and complete my insurance claim. I understand that this authorization may include release of information regarding communicable diseases, such as AIDS, HIV, and/or drug or alcohol testing/abuse. I understand that I am financially responsible for the total charges for services rendered which may include services not covered by my insurance companies and/or employer. I agree that all amounts are due upon request and are payable to Digestive Disease Consultants, LTD. I further understand that if my account should become delinquent, I shall pay the reasonable attorney fees or collection expenses of Digestive Disease Consultants, LTD., if any. **Fill out below information if insurance is through someone other than the patient:**

Name:_________________________ DOB: _____________________ Relationship to pt:_________________________________

Address:____

Home Phone**:**_________________________ Work Phone:_________________________ Cell Phone__________________________

______________**Patient Initials**

CONSENT TO TREAT

Do you have a Power of Attorney for Healthcare? ____YES ____NO (If so please list name(s)/phone number(s):___________________
____(Please provide copy of POA for your chart)

I hereby authorize employees and agents; including physicians, physician assistants and nurse practitioners; of Digestive Disease Consultants, LTD. to render routine medical care to the patient indicated on this form and to fulfill the orders of the physicians; including consultants, associates and assistants of the physician's choice _______________

Patient Initials

HIPAA Privacy Notice **(new patients only)** **Acknowledgement of receipt/review of notice** _________________________

Patient Initials

HIPAA AUTHORIZATION

I understand that as part of my healthcare, Digestive Disease Consultants, Ltd. (Covered Entity) creates and maintains health records describing my health history. I understand that the covered entity may use this information as: (1) a basis for planning my care and treatment (2) a means of communication among many health professionals who contribute to my care (3) a means by which third-party payors can verify that services billed were actually provided and (4) a tool for routine health care operations such as assessing quality and reviewing.

For further explanation or for a copy of our HIPAA Privacy Notice please see the front desk staff or visit our website at www.digestiveconsultant.com
This release is effective until revoked by patient with written notice/signature.

I request the following restrictions to the use or disclosure of my health information (as described above) Please mark one

_____ No Restrictions _____ Restrictions: (please list your requested restrictions)______________________________

Please initial selections that apply:

____ May share my protected health information with: Please list name(s) and relationship (ie spouse, relative, friend)

____

____ May leave messages regarding my health care and billing account on my home / cell phone (please circle)

____ Name and number of emergency contact (please list relationship)____

Primary Language______________________________Race_______________________Ethnicity___________________________

How did you hear about us? Friend Family Member Co-Worker Radio Web Site Print Ad
(Please circle) Publication / Article Health Fair Doctor /ER Yellow Pages TV Commercial

_______________________________________ _______________________

Signature of Patient, Parent, or Legal Guardian **Date**

Updated 9-2-16