GLST GASTROINTESTINAL & LIVER SPECIALISTS OF TIDEWATER, PLLC

PATIENT INFORMATION

Family Dr.: Phone #: Referring Dr.: Phone #:

How did you hear about our practice?

Patient Name: Email for Patient Portal:

Mailing Address: PO Box:

City: State: Zip Code:

Home Phone: ( ) Work Phone: ( ) Cell Phone: ( )

Preferred method of contact: □ Email □ Cell □ Home □ Work

Social Security Number: Date of Birth: Language:

Sex: (please check one) □ M □ F Race: Ethnicity:

Marital Status: (please check one) □ Married □ Single □ Divorced □ Widowed □ Other

Spouse's Name: SSN:

Date of Birth: Cell Phone: ( ) Employer:

Address (if different from above):

OCCUPATION INFORMATION

Employer: Occupation: Phone#:

PHARMACY

Name: Phone Number: ( )

Address: City: State: Zip Code:

EMERGENCY CONTACT INFORMATION (someone not living in the same household)

Name: Relationship:

Home Phone: ( ) Work Phone: ( )

City: State:

INSURANCE INFORMATION: IT IS YOUR RESPONSIBILITY TO KNOW IF YOU NEED A REFERRAL.

Primary Insurance Name: Name of Insured:

ID Number: Relationship to Insured:

SS# of Insured: DOB of Insured:

Secondary Insurance Name:

ID Number: Group Number:

Name of Insured: Relationship to Insured:

SS# of Insured DOB of Insured:

Provide name and approximate dates if previously seen by another Gastroenterologist:

GASTROINTESTINAL & LIVER SPECIALISTS OF TIDEWATER, PLLC

AUTHORIZATION FOR TREATMENT & ASSIGNMENT OF BENEFITS

This will authorize the filing of any insurance in force and the direct payment to Gastrointestinal & Liver Specialists of Tidewater, PLLC of any amount due on my claim under the above stated policy. I understand that my insurance policy is a contract between me and my insurance company and that I am financially responsible to Gastrointestinal & Liver Specialists of Tidewater, PLLC for non-payment of any fees not covered by insurance. I understand and agree to pay in full any balance due after an insurance payment or to make payment arrangements with Gastrointestinal & Liver Specialists of Tidewater, PLLC. In consideration of service rendered, the undersigned patient, spouse, and/or responsible party agrees to pay all cost of collections including attorney's and/or collection agency's fees in the range of 28 - 33-1/2% plus court cost and any interest allowable by law, if incurred. The practice at its discretion may apply a finance charge of 1.5% per month (18% APR) commencing 60 days from the date of service. I hereby authorize the release of any medical information necessary to process claim.

Patient Signature: _____ Date: _____

DEEMED CONSENT FORM

I understand that the laws of Virginia provide if my physician or any person employed by or under the direction and control of my physician(s) is directly exposed to my body fluids in any manner which may according to the then current guidelines for the Center of Disease Control transmit the human immunodeficiency virus (HIV) or hepatitis B or C viruses that I am deemed by law to have consented to testing for infection with HIV or hepatitis B or C viruses. I further understand that by law I will have deemed to have consented to the release of these test results to the person who is exposed to my bodily fluids.

Patient Signature: _____ Date: _____

ACKNOWLEDGEMENT OF HIPAA PRIVACY PRACTICES/ CANCELLATION/ NO SHOW POLICY

1. _____(Initial) I hereby acknowledge that I have had the opportunity to review a copy of the Notice of Privacy Practices. Please list anyone you are authorizing to have access to your medical records:

Name: _____ Relationship: _____ DOB#: _____

Name: _____ Relationship: _____ DOB#: _____

2. _____(initial) I hereby acknowledge that I understand there is a **$150.00** cancellation fee for procedures not canceled within **72 hours**, and a **$50.00** fee for office visits not canceled within **72 hours.**

ACKNOWLEDGEMENT OF CONTINUOUS QUALITY IMPROVEMENT PROGRAM

Our organization participates with the Accreditation Association for Ambulatory Health Care (AAAHC) requirements for quality improvement. Due to these requirements, I acknowledge that there is a Continuous Quality Improvement program in place which requires patient medical records to be reviewed periodically. I agree to allow my medical record to be reviewed if it is selected as part of the program. I understand my information will be remain confidential and will not leave this facility.

Patient Signature: _____ Date: _____