

**PATIENT AND INSURED (SUBSCRIBER) INFORMATION**

PATIENT'S NAME (PLEASE PRINT) LAST		FIRST	M.I.	SOCIAL SECURITY NO.		MARITAL STATUS					SEX		DATE OF BIRTH
						S	M	W	D	SEP	M	F	
STREET ADDRESS				CITY		STATE	ZIP CODE		HOME PHONE NO.				
FAMILY PHYSICIAN (PLEASE GIVE FIRST AND LAST NAME)				REFERRING PHYSICIAN (PLEASE GIVE FIRST AND LAST NAME)									
EMPLOYER						WORK PHONE NO.			CELL PHONE NO.				
EMPLOYER'S ADDRESS						CITY			ST	ZIP CODE			
NAME OF SPOUSE OR GUARDIAN						SPOUSE'S BIRTHDAY			SPOUSE'S SOCIAL SECURITY NO.				
SPOUSE'S EMPLOYER & ADDRESS											SPOUSE'S WORK PHONE NO.		
NEAREST RELATIVE NOT LIVING WITH YOU		ADDRESS		CITY		ST	ZIP CODE		PHONE NO.				
PATIENT'S E-MAIL ADDRESS:													

**INSURANCE INFORMATION**

PRIMARY	NAME OF PRIMARY INSURANCE COMPANY		ADDRESS				CONTRACT NO.		GROUP NO.		
	NAME OF INSURED (AS IT APPEARS ON YOUR INS. CARD)			AMOUNT OF CO-PAY		SUBSCRIBER'S BIRTHDAY					
SECONDARY	NAME OF PRIMARY INSURANCE COMPANY		ADDRESS				CONTRACT NO.		GROUP NO.		
	NAME OF INSURED (AS IT APPEARS ON YOUR INS. CARD)			AMOUNT OF CO-PAY		SUBSCRIBER'S BIRTHDAY					
ARE YOU INSURED UNDER YOUR SPOUSE'S INSURANCE?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	IF YES NAME OF INS. CO.				CONTRACT NO.		GROUP NO.	

**CONSENT TO TREAT**

I (Or my legal guardian or parent) authorize Birmingham Gastroenterology Assoc. to provide medical care reasonable by today's standards.

Signature of patient/legal guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**INSURANCE COVERAGE WAIVER**

I understand that my eligibility for coverage by my insurance cannot be confirmed at this time. I wish to receive medical service from Birmingham Gastroenterology Assoc. If it is determined that I am not eligible for coverage, I understand that I will be responsible for payment of all services provided. As a subscriber of my insurance plan I understand that if a referral is necessary for any visit to a specialist's office that it is my responsibility to assure that referral is obtained and current, prior to the scheduled visit. I therefore agree to pay for any charges not covered by my insurance due to not obtaining a referral from my primary care physician.

Signature of patient/legal guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**ASSIGNMENT OF INSURANCE BENEFITS**

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO Birmingham Gastroenterology Associates, P.C. of benefits otherwise payable to me including major medical insurance and payment of surgical or medical benefits, but not to exceed the physician's regular charges for these services. I understand that I am financially responsible to Birmingham Gastroenterology Assoc., P.C. for charges not covered by this assignment. I authorize the refund of overpaid benefits where my coverage's are subject to coordination of benefits. In the event of default, I agree to pay all costs of collection including reasonable attorney's fees, and waive all claims of exemption under the law of the State of Alabama.

Signature of patient/legal guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**PATIENT PRIVACY CONSENT FORM**

By signing this form, you are granting consent to Birmingham Gastroenterology Assoc. to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. you have a legal right to review our Notice of Privacy Practices before you sign this consent. and we encourage you to read it in full. Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by: (accessing our web site/contacting our organization at (205) 271-8000). You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement. You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

Signature of patient/legal guardian: \_\_\_\_\_ Date: \_\_\_\_\_