

**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: \_\_\_\_\_

EFFECTIVE \_\_\_\_\_ APRIL 14, 2003 \_\_\_\_\_

**Birmingham Gastroenterology Associates  
NOTICE OF PRIVACY PRACTICES**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

This notice will tell you about the ways in which we may use and disclose medical information about you. Not every use or disclosure in a category will be listed but all of the ways we are permitted to use and disclose information will fall within one of the categories. We reserve the right to change this notice. We reserve the right to make the revised notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in plain view. Each time we revise our notice, we will post it in our office and make it available to you upon request.

We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- ! Make sure that medical information that identifies you is kept private;
- ! Give you this notice of our legal duties and privacy practices with respect to medical information about you;
- ! Make a good faith effort to obtain your acknowledgement that you have received this notice; and
- ! Follow the terms of the notice is currently in effect.

**FOR TREATMENT:** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, or other personnel in our organization who are involved in taking care of you. For example, we may need to tell a nurse about your condition in order to coordinate the different things your need, such as lab work. We also may disclose medical information about you to health care providers outside our organization who are involved in your treatment, such as consulting physicians.

**FOR PAYMENT:** We may use and disclose medical information about you so that the services you receive from us or other providers may be billed and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about treatment you received, so your health plan will pay us or reimburse you for the treatment, or to obtain prior approval or determine whether your plan will cover the treatment.

**FOR HEALTH CARE OPERATIONS:** We may use and disclose medical information about you for our operations and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine the medical information we have with medical information from other similar organizations to compare how we are doing and see where we can make improvements in the care and services we offer. We will remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning who the specific patients are.

**OTHER USES OF MEDICAL INFORMATION**

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. All disclosures of psychotherapy notes require your written authorization. If you give us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission.

- We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment.
- We may use and disclose medical information to tell you about or recommend treatment options or alternatives or other health-related benefits or services that may be of interest to you.
- Unless you object, we may include certain limited information about you in our directory while you are a patient here. This information may include your name, location, your general condition (e.g., fair, stable, etc.) and your religious affiliation. The directory information, except for your religious affiliation, may also be released to people who ask for you by name. Your religious affiliation may be given to a member of the clergy, such as priest or rabbi, even if they don't ask you by name. This is so your family, friends and clergy can visit you while you are a patient with us and generally know how you are doing.
- If you do not object, we may release medical information about you to a friend or family member who is involved in your medical care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

- Under certain circumstances, we may use and disclose medical information about you for research purposes. We will almost always ask for your specific permission if the researcher will have access to information that reveals who you are, or will be involved in your care.
- We will disclose medical information about you when required to do so by federal, state or local law.
- We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.
- If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate donation and transplantation.
- If you are a member of the armed forces, we may release medical information about you are required by military command authorities.
- We may release medical information about you to your employer for workers compensation or similar programs.
- We may disclose medical information about you for public health activities (such as reports of communicable diseases, births and deaths, child abuse or neglect, reactions to medications or problems with products), to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease, or to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence.
- We may disclose medical information to a health oversight agency for activities such as audits and investigations that are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
- If you are involved in a lawsuit or dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if a reasonable effort has been made to tell you about the request or to obtain an order protecting the information requested.
- We may release medical information if asked to do so by a law enforcement official: in response to a court order, subpoena, summons or similar process; to identify or locate a suspect, fugitive, material witness, or missing person; about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement; about a death we believe may be the result of criminal conduct; about criminal conduct at this organization; and in emergency circumstances to report a crime, the location of the crime or victims, or the identify, description or location of the person who committed the crime.
- We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.
- We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law
- We may disclose medical information about you to authorized federal officials so they may provide protection to the President of the United States, other authorized persons or foreign heads of state or conduct special investigations.
- If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official if necessary.

## RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have the right to:

- Request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations, or to someone who is involved in your care. For example, you could ask that we not use or disclose information about a procedure you had.
- Request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.
- Inspect and copy the medical records we have about you.
- If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information.
- Request a list of the disclosures we made of medical information about you, except for treatment, billing and health care operations, or as a result of your written authorization.

To exercise these rights, make the request in writing. As the receptionist for the proper form. We have the right to deny your request in certain limited circumstances.

### Questions and Complaints

If you believe your privacy rights have been violated, you may file a complaint with this organization or with the U.S. Secretary of the Department of Health and Human Services. To file a complaint with us, contact our Privacy Officer at 205-271-8019, whose name is posed at the check out desk. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.** Please also contact the Privacy Officer if you need further information.



**PERMISSION TO DISCLOSE PROTECTED HEALTH INFORMATION  
 CONSENT AND ACKNOWLEDGEMENT  
 FOR BIRMINGHAM GASTROENTEROLOGY ASSOCIATES, P.C.**

(PLEASE PRINT)

Patient Name \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient Address \_\_\_\_\_ SSN: \_\_\_\_\_

I give Birmingham Gastroenterology Associates, P.C. permission to release medical information to the follow persons:

- None
- Parents \_\_\_\_\_  Spouse \_\_\_\_\_
- Father (only) \_\_\_\_\_  Mother (only) \_\_\_\_\_
- Other \_\_\_\_\_  Guardian \_\_\_\_\_

I wish to be contacted in the following manner by Birmingham Gastroenterology Associates, P.C. (check all that apply):

- Home Telephone** \_\_\_\_\_  **Written Communication**
  - O.K. to leave message with detailed information
  - Leave message with call back number only
  - O.K. to mail or Email to my home address
  - O.K. to mail or Email to my work/office
  - O.K. to fax to this number
- Work Telephone**
  - O.K. to leave with detailed information
  - Leave message with call back number only
- Other (Email address)** \_\_\_\_\_

The Privacy Act generally requires healthcare providers to take responsible steps to limit the use of disclosure of and requests for protected health information to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of protected health information disclosures. Information provided below, if completed properly, will constitute an adequate record.

**Consent:**

I consent to the use and disclosure of protected health information about me by my physician and my physician’s practice for purposes of treatment, payment, health care operations, protection of others and disclosures required by law, including information about notifiable diseases, sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) and human immunodeficiency virus (HIV).

NOTE: Uses and disclosures for protected health information may be permitted without prior consent in an emergency.

**ACKNOWLEDGMENTS:**

I acknowledge that I have received Birmingham Gastroenterology Associations, P.C. Notice of Privacy Practices.

\_\_\_\_\_  
 Signature of Patient or Personal Representative

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Relationship of Personal Representative to the Patient

\_\_\_\_\_  
 Signature of Witness

\_\_\_\_\_  
 Print Personal Representative’s Name

## **Birmingham Gastroenterology Associates Financial Policy**

### **Co-Pays**

The patient is expected to present the insurance card at each visit. All co-payments and past due balances are due and payable at the time of service. Any balance past due for 30 days will incur late fees and are subject for collection.

### **Self-Pay Accounts**

Self-pay accounts are patients who are covered by carriers that the practice does not participate in, patients without an insurance card on file or at the time of service or patients who have not met their deductible. It is expected that payment is required at the time of service for all services including surgeries.

### **Extended Payments Arrangements**

For procedures exceeding \$250.00: 75% of the total fee from an office visit is to be paid at the time of service or 50% of the total fee for a surgical procedure is to be paid prior to the procedure. The remaining balance is to be paid over the next three months in equal monthly payments due by the 15th of every month. Payments that exceed 30 days will incur late fees and are subject for collection. Patients who fail to make a monthly payment will be sent to a collection agency.

### **Non-Participating Insurance Accounts**

The financial obligations of patients who are insured by carriers that the practice does not participate are considered a Self-Pay Account. The insurance company will be billed as a courtesy to the patient. If payment is received for an account that is previously paid, the patient will receive a refund.

### **Checks Received "Paid In Full"**

The balance on the patient statement does not reflect charges pending with insurance carriers. Therefore, it is the policy of this practice not to accept check marked "Paid In Full".

### **Patient Refunds**

The following criteria must be met prior to issuing a patient refund: The patient has not been seen in the office for 90 days; there is no outstanding insurance claims on the patient's account.

### **Divorce Cases**

In case of divorce, the individual who receives the care is responsible for payments of co-pays, co-insurance and nonparticipating insurance balances at the time of service. We will not bill a divorced spouse for the patient's services.

### **Child Custody Cases**

The parent with primary custody is usually the parent with whom the child lives with and who usually brings the child to the office for care. Therefore, the parent with custody is also responsible for payment at the time of service whether the account is considered self-pay, participating insurance or non-participating insurance. If the non-custodial parent carries the insurance on the child, we will bill that insurance company. We do not get involved with the specifics of the divorce, such as, one parent pays 80% and the other pays 20%. It is the obligation of the parents to work out this agreement among themselves or with the court system.

### **Referrals**

If your insurance has designated a primary care physician (PCP), you are required to have prior authorization from your PCP prior to your office visit. If this authorization is not provided, you will be asked to either reschedule your appointment or pay for your visit at the time of service. It is our hope that the above financial policy will allow us to provide quality care to our valued patients. If you have any questions or need clarification of any of the above policies, please do not hesitate to contact our business office.

\_\_\_\_\_  
**Patient Signature / Date**

