HAC Patient Registration Form

Date________________________

PATIENT INFORMATION

Patient Name (Last)______________________ (First)______________________ (Middle)______________

Address______________________________ City__________________ State__________ Zip________

911 Address (if different from above) ____

Sex: M/F________ Birth date______________ Age________ Social Security #__________________

Marital status: (circle one) S M W D Race: (circle one) Asian Black Native American White Other______________

Home Phone____________________ Cell Phone ________________________

Employer______________________________ Work Phone______________ (Circle one): Full time Part time

Email Address:______________________________ Referring Physician________________________

Emergency contact____________________ Relationship to patient ______________ Phone No.______________

Spouse's Name (if applicable)____________________ Spouse's Social Security # ______________ Spouse's Birth date __________

Spouse's Employer ______________________________ Work phone ________________

Employer Address __________________________ City, State & Zip ________________________

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(If patient is less than 18 years of age)

RESPONSIBLE PARTY (Circle one) Father Mother Guardian Other ____________________

(If different from patient information)

Responsible party's name__________________________ Responsible party SS#______________ Sex: M/F______

Address__________________________ City, State & ZIP______________________________

911 Address (if different from above) ____

Responsible party Birth date__________________ Responsible Party Employer____________________________

Employer Address __________________________ City, State & Zip ________________________

OTHER PARENT/GUARDIAN INFORMATION

Name____

Address__________________________ City, State & ZIP______________________________

Relationship to Patient __________________ Employer________________________

Employer Address __________________________ City, State & Zip ________________________

SS#__________________ Birth date__________________ Sex: M/F__________

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PRIMARY INSURANCE

Name of Insurance Company____________________________ Policy Holder________________________

Pt. Relation to Policyholder____________________ ID#________________ Group#________________

Ins. Phone No.____________________ Policyholder's Birth date__________________ Sex: M/F__________

SECONDARY INSURANCE

Name of Insurance Company____________________________ Policy Holder________________________

Pt. Relation to Policyholder____________________ ID#________________ Group#________________

Ins. Phone No.____________________ Policyholder's Birth date__________________ Sex: M/F__________

Physicians Pavilion
2232 Wilborn Ave, Suite G
South Boston, VA 24592
(Tel) 434.572.8196

Consent To Treat

I, the undersigned, hereby consent to and authorize the administration and performance of all treatments, the administration of any needed anesthetics; the performance of such procedures as may be deemed necessary or advisable in the treatment of this patient, the use of prescribed medication; the performance of diagnostic procedures; the taking and utilization of cultures and performance of other medically accepted laboratory test, all of which in the judgment of the attending physician or their assigned designees, may be considered medically necessary or advisable.

I fully understand that this consent is given in advance of any specific diagnosis or treatment. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I hereby authorize Southern Gastroenterology Associates to release medical information to any of my physicians or insurance companies that may be pertinent to my case. I hereby authorize payment directly to Southern Gastroenterology Associates of benefits otherwise payable to me. I hereby authorize release of my medical records to third party insurers or other authorized persons to whom disclosure is necessary to establish or collect a fee for the services provided. I understand that I am financially responsible for charges not covered by this authorization. A photocopy of this authorization shall be considered as valid as the original. Further, I acknowledge that if I am indebted for past due charges that I am financially responsible for those charges also.

I consent and authorize Southern Gastroenterology Associates to collect my personal medical information in order to obtain and maintain on file the information necessary to verify and process electronic prescriptions. The received information can include prescription insurance eligibility, prescription insurance claims history, and prescription insurance formulary files.

I consent and authorize Southern Gastroenterology Associates to transmit prescription information to the pharmacy of my choice through a third party intermediary operating under a business associate agreement with the electronic prescription software vendor.

I further consent to these options:	Publish Data to My Halifax Medical Record	YES	NO
	Transmit Data to Immunization Registry	YES	NO
	Receive Immunization Reminders from the Registry	YES	NO
	Should the Immunization Registry Protect Data	YES	NO
	Mail Order Prescriptions Preferred	YES	NO

Preferred Method of Contact: Mail/Letters Phone Call My Halifax Medical Record No Preference

MEDICARE PATIENTS: I authorize Southern Gastroenterology Associates to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to Southern Gastroenterology Associates. In accordance with the provisions of Section 32.1-45.1 of the Code of Virginia, (whenever any healthcare provider, or any person employed by or under the direction and control of a health care provider, is directly exposed to body fluids of a patient in a manner which may, according to the current guidelines of the Centers of Disease Control, transmit human immunodeficiency virus), the patient whose body fluids were involved in the exposure shall be deemed to have consented to testing for infection with human immunodeficiency virus. If there is an exposure, and the patient's test is positive, the attending physician will notify the patient, any person exposed and the Virginia Health Department and appropriate counseling will be offered. I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Email Address: ____

Patient's Signature (or responsible party) ____

Date: ___________________________________

SUMMARY NOTICE OF PRIVACY PRACTICES

This is a summary and the detailed notice describes how medical information about you may be used and disclosed. Please review it carefully.

Southern Gastroenterology Associates (SGA) collects health information from you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of SGA, but the information in the medical record belongs to you. SGA protects the privacy of your health information. The law permits SGA to use or disclose your health information for the following purposes:

- **Treatment :** Example: an SGA nurse may read your medical chart in order to care for you
- **Payment:** Example: We may send information about you to your insurance company in order to get paid.
- **Regular Health Care Operations:** Example: We may provide health information to students who are authorized to receive training in our facility.

As a Patient you have the following rights:

- Right to Notice of Privacy Practices
- Right of access and inspection
- Right to amend
- Right to authorize non-treatment uses
- Right to accounting of disclosures
- Right to request restrictions on use
- Right to request alternative channels of communication
- Right to complain to entity or SGA.

Effective Date of this notice: 04/19/2014.

ACKNOWLEDGEMENT OF RECEIPT

This is to acknowledge that I have read this Summary Notice of Privacy Practices and may request a copy for my files.

Name: ____

Signature: ____ **Date:** ________________

Relationship if other than patient: ______________________________

NOTICE OF INFORMATION PRACTICES

1. Southern Gastroenterology Associates may use and disclose protected health information, payment and healthcare operations. Examples of these include, but are not limited to, requested preschool or sports physicals, referral to nursing homes, foster care homes, home health agencies and/or insurance companies for claims including coordination of benefits with other insurers. Healthcare operations include but are not limited to internal quality control and assurance including auditing of records.
2. Southern Gastroenterology Associates is permitted or required to use or disclose protected health information without the individual's written consent or authorization in certain circumstances. Two examples of such are for public health requirements or court orders.
3. Southern Gastroenterology Associates will not make any other use of disclosures of a patient's protected health information without the individual's written authorization. Such authorizations may be revoked at any time. Revocation must be written.
4. Southern Gastroenterology Associates will abide by the terms of this notice currently in effect at the time of the disclosure.
5. Southern Gastroenterology Associates reserves the right to change the terms of its notice and to make new notice provisions effective for all protected health information that it maintains. Southern Gastroenterology Associates will provide each patient with a copy of any revisions of its Notice of Information Practices at the time of their next visit, or at their known address if there is a need to use or disclose any protected health information of the patient. Copies may also be obtained at any time at our offices.
6. Any patient, guardian or personal representative has the right to object to the use of their health information for directory purposes.
7. Any parent, guardian or personal representative has the right to request to inspect and obtain copies of their medical record.
8. Any patient, guardian or personal representative has the right to request amendments be made to their medical record.
9. Any patient, guardian or personal representative has the right to request a six-year accounting of all disclosures of their medical records. The history will be provided within 60 days of the request and a reasonable charge maybe assessed for any copies after the first requested in a 12-month period.
10. Any patient, guardian or personal representative has the right to request restrictions as to how their health information may be used or disclosed to carry out treatment, payment or healthcare operations. The Practice is not required to agree to the restriction requested, but if the Practice does agree, the Practice must abide by those restrictions.
11. Any person/patient may file a complaint to the Practice and to the Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with the practice, please contact the Privacy Officer at the following address and/or phone number, Southern Gastroenterology Associates, 2232 Wilborn Ave, Suite G, South Boston, VA 24592, telephone 434-572-8196 and fax number 434-572-8341. All complaints will be addressed and the results will be reported to the Privacy Officer.
12. It is the policy of Southern Gastroenterology Associates that no retaliatory action will be made against any individual who submits or conveys a complaint or suspected or actual non-compliance of the privacy standards.

Effective date 4-9-03. Date:____

Name of Patient____

Signature of Patient or Legal Guardian____

HIPAA Notice of Information Practice Disclaimer: Contents are informational and not intended as legal advice, NCRIC MSO, Inc. and its subsidiaries, its employees, agents and staff, make no representation, guarantee or warranty, express or implies, that these forms are error-free or that the use of this information will present differences of opinion or disputes with any other party, and will bear no responsibility or liability for the results of consequences of its use. Reviewed Aug 2012

2232 Wilborn Avenue, Suite G
South Boston, VA 24592

Telephone: (434) 572-8196 Fax: (434) 572-8341

PERMISSION TO DISCUSS PERSONAL HEALTH INFORMATION (PHI)

Patient Name: ____

Date of Birth: ______________________________

Account Number: ___________________________

NAME	RELATIONSHIP
____	_____________________
____	_____________________
____	_____________________
____	_____________________
____	_____________________
____	_____________________

Signature of Patient, Parent or Guardian:____

Date: ______________________________________

***In order to obtain information by telephone, the party calling the practice must share the patient identifier with the staff.**

Patient identifier: ___________________________ (Patient Date of Birth)

FINANCIAL POLICY

SOUTHERN GASTROENTEROLOGY ASSOCIATES

We are committed to providing you with the best possible medical care; if you have special needs; we are here to assist you. The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services.

1. Our office participates with a variety of insurance plans. It is your responsibility to:
   - Bring you insurance card every visit.
   - Be prepared to provide 2 forms of government issued identification, indicating address, one with a picture.
   - Be prepared to pay your co-payment or co-insurance at each visit. Payment can be made by cash, check, debit or credit card.
   - For medical care <u>not covered</u> under your insurance, payment in full is due at the time of the visit.
2. If you have insurance that we <u>do not participate in,</u> our office is happy to file the claim; however, payment in full is expected at the time of service unless other arrangements have been made.
3. Referrals: it is your responsibility to bring any required referrals for treatment at, or prior to, the visit. If you do not have the referral, your visit may be rescheduled, or you may be financially responsible.
4. If you <u>do not have insurance</u>, a down payment is expected at the time of the visit. If additional services are provided during that visit, such as EKG's, injections, labs, etc., additional charges maybe applied for services rendered. You will be responsible for the remainder of the billed amount for those services. You may be eligible to set up payments, inquire if necessary.
5. If the patient is a minor (age 18 and younger), the parent or guardian must sign below. The parent, guardian, or unaccompanied minor is responsible for any payment due at time of service, bringing the necessary referrals and insurance card.
   * In certain situations, parent or guardian signature is not required.*
6. If you have questions about your insurance, we are happy to help you. Specific coverage issues, however, should be directed to your insurance company member services department (number is on the insurance card).
7. If you fail to make payment in full for the services that are rendered to you, within 90 days, outstanding balance will be sent to a collection agency. You will be responsible for and agree to pay all reasonable collection costs including late charges, interest, court costs and/or attorney's fees.
8. I authorize Southern Gastroenterology Associates and its agents, the use of any telephone number including wireless numbers, provided to them or published, to message or contact me regarding my accounts.

Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communications. Please sign that you have read and agree to the terms of this Financial Policy.

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Signature of Patient or Responsible Party Date