Gi Specialists of Clarksville, PC · Anil Patel, MD MBA, PC

Name: _____ County: _____

Address:_____ City:_____ State: ____ Zip Code:_____

Home #: _____ Cell #: _____ Work#: _____

Date of Birth:_____ Age:_____ E-mail address for portal:_____

Social Security #: _____ Employer: _____

Marital Status: _____ Spouse's Name: _____ Spouse's Employer:_____

Guarantor or Sponsor: _____ Date of Birth:_____ Social Security:_____

Emergency Contact: _____ Phone #: _____ Pharmacy:_____

Organ donor:_____ Advance Directive or DNR: _____ (Important Note: We do not honor advance directives at our facility.)

Family Doctor: _____ Referred By:_____ Gastroenterologist seen in past:_____

HIPAA POLICY

1. May we leave a message on your voicemail to confirm an appointment and/or procedure? **Yes No not applicable**
2. May we leave a message on your voicemail when we make our courtesy post operative phone call? **Yes No not applicable**
3. Do we have your permission to leave a message with anyone who answers any of the phone numbers listed above? **Yes No**
4. Do we have your permission to leave test results with anyone who answers phone or leave a message on voicemail? **Yes No**
5. Would you like to use the secure Internet Patient Portal to access your health information & communicate via e-mail? **Yes No**

I have read and understood the HIPAA Privacy Practice Notice. **Initial:** _____

OFFICE POLICY

- There will be a $25 charge for a copy of your medical records that are not requested by another physician. There will be a $25 charge for filling out disability records, work-related forms, etc. There will be a $25 charge for a returned check due to insufficient funds. You will be charged $75 for any appointment not cancelled prior to visit, for missing an appointment.
- You will be charged $150 for any procedure not cancelled prior to scheduled slot, for a No Show appointment.
- Procedure must be scheduled within 30 days of the consultation visit, as per State Regulations.
- There is a 3% fee for payments made by credit card as this amount is charged to us by the credit card company.

Initial: _____

INSURANCE BILLING POLICY & PAYMENT

What will my insurance be billed for? Consultation and/or follow-up visit. Plus there will be 4 charges for a procedure, if done.

- The insurance co-pay, as indicated on your insurance card, is to be paid prior to the office visit and/or outpatient surgery.
- If your deductible has not been met, then we will collect up to $1500 — $2000 prior to the procedure or your copay.
- We will bill only the insurance companies for which proof of coverage has been provided. There is a $25 fee to refile claim.
- The account balance will be due within 90 days of the service and treatment date.
- You, the patient, are responsible for contacting your insurance provider about non-payment, delays in payment and reduced payment.

1. Charge for the doctor, Dr. Anil Patel. This is for the doctor doing the procedure.
2. Charge for the endoscopy center, Gi Specialists of Clarksville, or the hospital will bill your insurance if your procedure is done there. This bill is for the use of recovery room, procedure room, sedation, discharge.
3. Charge for the anesthesia service for Propofol sedation by CRNA by Warfield Anesthesia PC.
4. Charge for the biopsy(s) professional and technical component by the pathology laboratory.

Initial: _____

TEST RESULTS POLICY

When you have any type of laboratory test, x-ray, biopsy, or other report pending, it is our office policy to request that you call if you have not received results within 30 days and you are not scheduled for a follow-up appointment. We do not want you to assume that results are normal if you have not heard from this office. This policy was adopted to ensure that we do not overlook any of our patients and to implement a program that involves each of you in your medical care. Test results can also be obtained via our HIPAA compliant patient portal for your request.

Initial: _____

ASSIGNMENT OF BENEFITS and RELEASE OF INFORMATION

- I authorize direct payment of surgical/medical benefits to Anil Patel MD PC and Gi Specialists of Clarksville PC for services rendered by him in person, an associate in the practice, or under his supervision. I consent & authorize Telehealth visits.
- I understand that I am financially responsible for any balance not covered by my insurance. I authorize Dr. Anil Patel to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit. A photocopy of these assignments shall be valid as the original.
- If this account goes delinquent, I will be responsible for all collection agency and/or attorney fees, and all other costs.
- Cell phone numbers provided to us on this form will be used to contact you regarding the above.

SIGNATURE:_____ **DATE:** _____

Chart No. _____ Registered by _____ ID scanned_____ Insurance Cards Scanned Primary _____ Secondary_____