Gulf Coast Gastroenterology
Fairhope | INFIRMARY HEALTH

Patient Name: _____ Patient Birthdate: ____/____/____
(*last*) (*first*) (*middle initial*)

Patient Sex: Male Female Patient Social Security #: ____/____/____ Marital Status: _____

Ethnicity (circle) American Indian Black Caucasian Hispanic Non Hispanic Other

Race: (circle) American Indian Asian Black or African American Caucasian/White Hispanic Non Hispanic Other

Mailing Address: _____

City: _____ State: _____ Zip: _____ E-mail: _____

Home Phone: (____)____-____ Cell: (____)____-____ Work Phone: (____)____-____

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Unemployed ☐ Student ☐ Retired

Employer: _____

Emergency Contacts

Name: _____ Relationship: _____

Home Phone: (____)____-____ Cell Phone: (____)____-____ Work Phone: (____)____-____

Primary Insurance Information ***Please present all insurance cards to the Front Desk***

Insurance Company: _____

Name of Policy Holder/Insured: _____ Insured Date of Birth: ____/____/____

Relationship to Patient:_____ Employment Status: ☐ Full-Time ☐ Part-Time ☐ Retired ☐ Unemployed

Seconday Insurance *(if applicable)*

Insurance Company: _____

Name of Policy Holder/Insured: _____ Insured Date of Birth: ____/____/____

Relationship to Patient: _____ Employment Status: ☐ Full-Time ☐ Part-Time ☐ Retired ☐ Unemployed

Person responsible for any balance on this account - (only if the patient is a minor)

Name: _____ Social Security #: ____/____/____

Relationship: _____ Birthdate: ____/____/____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____)____-____ Cell Phone: (____)____-____ Work Phone: (____)____-____

Employer: _____

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Retired ☐ Unemployed

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IMC-Patient Responsibility Consent Form

Patient Last Name _____ Patient First Name _____ Date of Birth ____/____/____

Assignment of Benefits

I request that payment of authorized Medicare and/or Medicaid benefits to be made on my behalf for services in or by the Clinic, shall be made to the Clinic, and I specifically assign such benefits to the Clinic. If applicable, I hereby assign and authorize payment directly to the Clinic of all medical benefits under any insurance or third party plan payable to me or which I am otherwise entitled.

Release of Information

I authorize any holder of medical information about me to release to Medicare, Medicaid, and/or other health insurance or third party plan and their respective agents any information needed to determine these benefits or related services.

Financial Responsibility

I understand that I am responsible for all charges not paid by my insurance plan except those amounts that the Clinic is contractually obligated to write off. I understand that I am responsible for all non-covered services and by signing this form I acknowledge I have been made aware of my obligation prior to receiving such services. I understand that if I do not pay for the charges for which I am responsible, the Clinic may turn my account over to a collection agency. I understand that should my account be turned over to a collection agency I may be charged a collection fee, not to exceed 25% of my account, and I accept these fees charged by the Clinic as a legal and lawful debt and agree to pay such fee if charged.

Telephone and Alternative Communication Consent

I understand the Clinic or its agents may use pre-recorded/artificial voice messages and or/auto-dialing devices to remind me about appointments or notify me of other information and I expressly consent to the Clinic or its agents use of any number associated with my account including any wireless number. I also authorize the Clinic or its agents to contact me at any number associated with my account, including wireless numbers, including contact by means of pre-recorded or artificial voice messages and/or automatic dialing devices, for the purposes of collecting on my account. I also authorize the Clinic to communicate with me using any email address I provide to the Clinic.

No Show Appointments

I understand when I make an appointment, time is reserved for me that cannot be scheduled for someone else. Recognizing this I will, exempting unforeseen emergencies, notify the Clinic no later than the business day before my appointment should I not be able to keep my appointment. If I do not, I understand the Clinic has the right to charge me a no-show fee and I acknowledge such a charge would be a legal and lawful debt and agree to pay such fee if charged.

Minors

I understand that I am responsible for this child's account and any agreement otherwise by means of a court decree or other valid agreement is between me and another party.

Authorization to Treat

I voluntarily consent to medical treatment and diagnostic procedures provided by the clinic. I am aware that the practice of medicine & surgery is not an exact science. I acknowledge that no guarantees have been made as to the results of treatments and/or examinations.

_____ ____/____/____

Patient (or Responsible Party) Signature Date

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Acknowledgement of Receipt of Privacy Practices (HIPAA)

You acknowledge that you were offered a copy of our Notice of Privacy Practices. If you would like to receive a paper copy at any time in the future, you can call (251) 990-0360.

_____ _____/_____/_____
Patient Name (please print) Date

_____
Signature

If the patient is unable to sign, please indicate the reason why:

_____ Admitted directly to treatment area
_____ Left AMA or without being seen
_____ Unresponsive
_____ Not competent (POA signed)
_____ Refused to sign
_____ Patient is a minor (Guardian signed)

Please list anyone with whom we can speak with about your account:

	Name	Relationship	Medical?	Billing?
1.	_____	_____	□Y □N	□Y □N
2.	_____	_____	□Y □N	□Y □N
3.	_____	_____	□Y □N	□Y □N
4.	_____	_____	□Y □N	□Y □N

☐ I do not wish to have my health care discussed with anyone.

FOR OFFICE USE ONLY

_____ _____/_____/_____
Facility Representative Date

GCG_89782

Gulf Coast Gastroenterology
Fairhope | INFIRMARY HEALTH

188 Hospital Dr., Suite 405
Fairhope, AL. 36532
251-990-0360 | Fax 251-990-0366

Use and disclosure of Protect Health Information (PHI) Authorization Form - Release of Information(ROI)

Patient Name: _____ Date of Birth: _____

By signing this Authorization Form, I understand I am giving authorization to IMC-Gulf Coast Gastroenterology, +medical record custodian, to release my protected health information including Medical, Psychiatric, Alcohol, HIV, Drug Abuse, Reproductive Healthcare and/or Financial Information contained in my records. I authorize IMC-Gulf Coast Gastroenterology to:

[ ] Disclose (release) to: or [ ] Obtain (request) from:

Name of Person or Organization: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Purpose of release: ☐ Continuity of Care ☐ Change of PCP ☐ Insurance Claim
☐ Personal Use ☐ Legal Use
☐ Other _____

Personal Health Information to be disclosed/or obtained:

☐ All Medical Records
☐ Lab Reports
☐ Operative Notes
☐ Pathology Reports
☐ Immunization Records
☐ Progress Notes
☐ Radiology Reports
☐ Other _____

Comments: _____

Medium to be Used: ☐ Paper, ☐ MyChart, ☐ CD/DVD, ☐ Email: _____

I understand that I can revoke this authorization at any time except to the extent that any action has been taken in reliance on this authorization. I can revoke this authorization by submitting a written request to IMC-Gulf Coast Gastroenterology.

This authorization will expire 1 year from the date of signing below unless specified otherwise. Date of expiration if different: _____

I understand that IMC-Gulf Coast Gastroenterology will not condition treatment or payment on whether you sign this authorization unless this authorization is for the provision of research-related treatment or for the creation of health information for disclosure to a third party.

_____ _____
Signature of Patient Date

_____ _____ _____
Signature of Authorized Representative Date Relationship

Records given to patient/representative on Date: _____ By Signature: _____

When selecting email as the medium to receive information you are accepting potential security risk associated with unencrypted email. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and is no longer protected under Title 45 CFR 160.