DIGESTIVE HEALTH SPECIALISTS OF THE SOUTHEAST
PATIENT INFORMATION

Last Name:______________________ First Name:________________________ Middle Initial:__________

Mailing Address:___________________________ Apt#:_______ City:____________ State:_____ Zip:_____

Home#:___________________ Work#:___________________ Cell#:______________________________

Age:_____ Sex: M F Date of Birth:____________ Marital Status:_____________ SS#:________________

Employer's Name:____

Address:_____________________________________ City:__________________ Zip:______________

Spouse Name:________________________________ Home#:________________ Work#:______________

Emergency Contact:________________________ Relationship:____________ Phone#:_________________

Patient Email:____

INSURANCE INFORMATION OF POLICY HOLDER

Primary Insurance:______________ Address:___________________ State/Zip:________ Phone#:_____________

ID#:______________________ Group#:_______________ Policy Holder Employer:_______________________

Policy Holder:___________________ Date of Birth:_______ SS#:__________________ Relationship:__________

Secondary Insurance:______________ Address:___________________ State/Zip:________ Phone#:___________

ID#:______________________ Group#:_______________ Policy Holder Employer:_______________________

Policy Holder:___________________ Date of Birth:_______ SS#:__________________ Relationship:__________

Patient Consent to Share Personal Health Information

I hereby authorize Digestive Health to share my personal health information with named persons below until further written notice from me:

Name:___________________ Relationship to Patient:____________________ Phone Number:_________________

Name:___________________ Relationship to Patient:____________________ Phone Number:_________________

❏ Decline all requests to share personal health info

Assignment and Authorization of Benefits

I hereby give authorization for payment of insurance benefits to be made directly to Digestive Health for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection and reasonable attorney fees. I hereby authorize this healthcare provider to release all information necessary to secure payment of benefits. I further agree that a photocopy of this Agreement is as valid as the original.

Acknowledgement of Review of Notice of Privacy Practices

I have been given the opportunity to review this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature:_______________________ Date:________________ Witness:____________________ Date:___________

DIGESTIVE HEALTH SPECIALISTS OF THE SOUTHEAST
FINANCIAL POLIGY

TO OUR PATIENTS:

Thank you for selecting our office for your medical care. In order to prevent any misunderstanding concerning the responsibility for payment for medical or surgical services provided to our patients, the following is supplied:

The patient or the guarantor is responsible for payment for services provided by Digestive Health Specialists of the Southeast at the time of service unless prior arrangements have been made. The only exception is if **Digestive Health Specialists of the Southeast** has contracted with your HMO/PPO insurance plan to accept the insurance payment as payment in full after all deductibles have been met and all co pays have been paid.

We will file a claim to your insurance company for each visit. If requested, we will furnish you with a copy of your bill for each visit, which contains all the information necessary for you to bill any personal reimbursement policies that you may have.

Charges for initial and return office visits will vary depending on the nature of your visit and if any procedures are performed. Additional tests or procedures, such a laboratory, radiology, or other diagnostic tests, will be billed separately by those providers.

HMO/PPO OR CONTRACTED INSURANCE COVERAGE

Certain health insurances (HMO,POS, etc.) require that you obtain a referral from your Primary Care Provider (PCP) or prior authorization from your insurance company before visiting a specialist or having a procedure done. Our team of insurance specialist will assist as a courtesy, but **you are primarily responsible for obtaining all required information.** Failure to obtain the referral and/or preauthorization may result in a lower or no payment from the insurance company, and the balance will be your responsibility. Alternative payment arrangements or rescheduling of your appointment may be necessary if not obtained.

MEDICAID

If you have Medicaid coverage, we must have your Medicaid card to verify coverage at the time of service and the required co-pay amount. If you have Medicaid coverage pending, we require payment for the services **at the time of your visit**. If, within three months after your visit, you provide a retroactive Medicaid card that covers the date of the visit, we will refund your payment after Medicaid pays for your visit.

MEDICARE

Our physicians are participating Medicare providers. Office visits and procedures by a doctor are covered under part B of the Medicare program. Medicare pays 80% of their allowable charges after you pay your **annual deductible for the calendar year.** If you have supplemental insurance, we require a copy of your insurance card and insurance mailing address.

I have read all the information above and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered.

In the event that your insurance company is billed, I authorize payment of medical benefits to be paid directly to **Digestive Health Specialists of the Southeast.** A photocopy of this agreement shall be considered as effective and valid as the original.

In the event that my account is placed with a collection agency or an attorney upon default of payment, I agree to pay all collection costs including attorney fees and court costs.

Signature ____ Date ________________________

Responsible Party ______________________________________ Date ________________________

I authorize the release of any medical information necessary to process my claims.

Signature ____ Date ________________________

Gastroenterologists:
D.F. Jackson, III, MD
William D. McLaughlin, MD
Robert P. Albares, MD
Jeffrey J. Crittenden, MD
Samuel J. Tarwater, MD
Travis J. Rutland, MD

334-836-1212 phone
334-836-1888 fax

Gastroenterologists:
Marc L. Clark, MD
Paul B. Lamb, MD
Scott A. Sarrels, MD
Tyler P. Black, MD
George A. Nelson, IV, MD
Pathologist:
Beth Rutland, MD

480 Honeysuckle Rd,
Dothan, AL 36305

PHYSICIAN/PATIENT DISCLOSURE FORM

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(Physician's Name)

The "Physician"

During the course of your physician/patient relationship with the Physician, the Physician may at a future time refer you to Dothan Surgery Center, LLC, which operates an ambulatory surgery center at 1450 Ross Clark Circle, Dothan, Alabama.

In connection with any such referral, the Physician hereby advises you that the Physician has an invested interest in Dothan Surgery Center, LLC and thus in its ambulatory surgery center.

Please be advised that you have the right to obtain the health care items and services for which the Physician refers you at any location or from any ambulatory surgery center, hospital, provider, or supplier of your choice, including Dothan Surgery Center.

I, the undersigned patient (the "Patient") received this Physician/Patient Disclosure Form from the above-referenced Physician, and I read and understand the information contained in this Physician/Patient Disclosure Form. The Physician furnished me with the Physician/Patient Disclosure Form prior to the Physician's referral of me to the Dothan Surgery Center, LLC.

Date: ________________________, 20__

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Signature of Patient

____
(Printed Name of Patient)

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(Home: Street Address of Patient)

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(Telephone Number of Patient)