DIGESTIVE HEALTH SPECIALISTS
PATIENT INFORMATION

Name: _____ Date of Birth: ___/___/____
First MI Last

Address: _____
Street City State Zip

Please Check One: □ Male □Female Social Security Number _____-_____-_____

Telephone #: _____ May we leave a message on this number □Yes □No

Cell#_____ May we leave a message on this number □Yes □No

Patient E-Mail Address: _____

Employer: _____ Work#: _____

Emergency Contact: _____ Phone#_____ Relationship: _____

Name of Primary Care Physician: _____ Phone#_____

Address: _____

INSURANCE INFORMATION

Primary Insurance: _____ Policy #_____ Group#_____

Address: _____ Phone#: _____

Policyholder: _____ DOB#____/____/____ SS#_____-_____-_____ Relationship: _____

Secondary Insurance: _____ Policy#_____ Group#_____

Address: _____ Phone#: _____

Policyholder: _____ DOB___/___/____ SS#____-_____-_____ Relationship: _____

PATIENT CONSENT TO SHARE PERSONAL HEALTH INFORMATION

I hereby authorize Digestive Health to share my personal health information with named persons below:

Name: _____ Relationship to patient_____ Phone#_____

Name: _____ Relationship to patient: _____ Phone#_____

□Decline all requests to share personal health info

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

Gastroenterologists:
William D. McLaughlin, M.D.
Robert P. Albares, M.D.
Jeffrey J. Crittenden, M.D.
Samuel J. Tarwater, M.D., FACG
Travis J. Rutland, M.D., FACG

Digestive Health Specialists
OF THE SOUTHEAST

Gastroenterologists:
Marc L. Clark, M.D.
Paul B. Lamb, M.D.
S. Andrew Sarrels, M.D.
Tyler P. Black, M.D.
George A. Nelson, IV M.D.

Pathologist:
Beth M. Rutland, M.D.

PHYSICIAN/PATIENT DISCLOSURE FORM

_____
(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 Gut Endo, LLC which operates as The Center for Digestive Health, an ambulatory surgery center located at 301 Medical Park Boulevard, Dothan, Al.

In connection with any such referral, the physician hereby advises you that the physician has an invested interest in Gut Endo, 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 The Center for Digestive Health.

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 Center for Digestive Health.

Date: _____

_____
Signature of patient

_____
Printed Name of patient

_____
Street address of patient

_____
Patient phone number

DIGESTIVE HEALTH SPECIALISTS OF THE SOUTHEAST
FINANCIAL POLICY

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 _____

Digestive Health Specialists
OF THE SOUTHEAST

D.F. Jackson, III, M.D.
William D. McLaughlin
Robert P. Albares, M.D.
Jeffrey J. Crittenden, M.D.
Samuel J. Tarwater, M.D.
Tyler Black, M.D

Travis J. Rutland, M.D.
Marc L. Clark, M.D.
Paul B. Lamb, M.D.
Scott A. Sarrels, M.D.
George Nelson, M.D.
Pathologist:
Beth Rutland, M.D.

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

480 Honeysuckle Rd. Dothan, AL 36305
Phone: 334-836-1212 Fax: 836-1888, 836-0096, 836-0097, 836-0173, 699-7592

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Important Notice

"No Show" Policy

We strive to make every effort to notify you of any upcoming scheduled procedure or upcoming scheduled office appointment by our automated reminder service that calls or sends out text reminders at two different times prior to your scheduled appointment.

We realize there may be times when you need to reschedule your appointment. We ask that you show consideration by notifying our office at least 24 hours in advance if you are unable to keep an appointment. We would like to have the opportunity to offer that appointment to another patient who needs to see the doctor.

This serves as notice that if you fail to give at least a 24- hour notice of cancellation in the future, there will be a $50 cancellation fee for a no-show appointment and a $200 no show fee for procedures.

Repeated missed appointments may result in dismissal from our practice.

I have read and understand the above policy.

_____ _____

Signature **Date**

480 Honeysuckle Road • Dothan, Alabama 36305 • P: 334.836.1212 • F: 334.836.1888
112 East Haven Drive, Ste. 2 • Dothan, Alabama 36301 • P: 334.305.0112 • F: 334.305.0114
614 N. Main Street, Ste. A • Enterprise, Alabama 36330 • P: 334.489.4244 • F: 334.475.4022
2126 Roy Parker Road, Ste. 202 • Ozark, Alabama 36360 • P: 334.443.0203 • F: 334.836.1888
www.digestivepros.com