Wichita Falls Gastroenterology New Patient Paperwork

PATIENT DEMOGRAPHIC INFORMATION

LAST NAME: _____ FIRST NAME: _____ MI: _____
DATE OF BIRTH: _____(mm/dd/yyyy) SEX: _____ RACE: _____
SOCIAL SECURITY #: _____ ETHNICITY: _____
ADDRESS: _____ APT/SUITE #: _____
CITY: _____ STATE: _____ZIP: _____

LANGUAGE: _____ MARITAL STATUS: ☐SINGLE ☐MARRIED ☐PARTNER ☐DIVORCED ☐WIDOWED
Whom may we thank for referring you to our practice? _____

CONTACT INFORMATION

HOME PHONE: _____ WORK PHONE: _____ EXT: _____
CELL PHONE: _____ EMAIL: _____

EMERGENCY CONTACT INFORMATION

CONTACT FIRST NAME: _____ CONTACT LAST NAME: _____
CONTACT PHONE #: _____ RELATIONSHIP TO PATIENT: _____

PRIMARY CARE

PHYSICIAN NAME: _____PRACTICE NAME: _____

PHARMACY

PHARMACY NAME: _____ PHARMACY LOCATION: _____

PRIMARY INSURANCE

INSURANCE COMPANY: _____ COPAY:_____
GROUP #: _____ MEMBER ID #: _____
INSURED FIRST NAME: _____ LAST NAME: _____ MI: _____
SOCIAL SECURITY #: _____ DOB: _____ RELATION TO PATIENT: _____
INSURED EMPLOYED BY: _____ BUSINESS PHONE #: _____

Additional Insurance

IS THE PATIENT COVERED BY ADDITIONAL INSURANCE? ☐ YES ☐ NO
INSURANCE COMPANY: _____ COPAY:_____
GROUP #: _____ MEMBER ID #: _____
INSURED FIRST NAME: _____ LAST NAME: _____ MI: _____
SOCIAL SECURITY #: _____ DOB: _____ RELATION TO PATIENT: _____
INSURED EMPLOYED BY: _____ BUSINESS PHONE #: _____

Is There a Third Insurance, we need to File? ☐ YES ☐ NO

EMPLOYMENT STATUS ☐EMPLOYED ☐ UNEMPLOYED ☐ RETIRED ☐ OTHER

OCUPATION: _____ BUSINESS NAME: _____

Authorization to release or use information for treatment, payment, or health care operations

I hereby authorize the release or use of my individually identifiable health information (protected health information or PHI) and medical information by **Wichita Falls GI Associates** in order to carry out treatment, payment, or health care operations. You should review the Practice's Notice of Privacy Practices for a more complete description of the potential release and use of such information, and you have the right to review such Notice prior to signing this Consent Form.

We reserve the right to change the terms of this Notice of Privacy Practices at any time. If we do make changes to the terms of its Notice of Privacy Practices, you may obtain a copy of the revised notice by writing our practice or requesting a copy from our front desk staff.

You retain the right to request that we further restrict how your protected health information is released or used to carry out treatment, payment, or health care operations. Our practice is not required to agree to such requested restrictions: however, if we do agree to your requested restriction(s), such restrictions are then binding on the Practice.

I agree and consent to releasing information to me in the following manners:

VIA MAIL — PLEASE INITIAL

☐ OK TO MAIL TO HOME ADDRESS _____

☐ OK TO MAIL TO WORK ADDRESS _____

VIA HOME TELEPHONE

☐ OK TO LEAVE DETAILED MESSAGE _____

☐ LEAVE CALL BACK NUMBER ONLY _____

VIA WORK TELEPHONE

☐ OK TO LEAVE DETAILED MESSAGE _____

☐ LEAVE CALL BACK NUMBER ONLY _____

VIA FAX

☐ OK TO FAX TO: _____

By signing below, I attest that all the information provided above is true and accurate. Your Insurance Card(s) and a Photo ID are required at your visit.

Signature of Insured/Guardian: _____ **Date:** _____

Wichita Falls Gastroenterology Associates (WFGIA)

Office and Financial Policies

The following policies are to help our patients understand their responsibilities with WFGIA. Please carefully review the following valuable information as it is intended to serve as your guide to a smooth and productive visit.

Initial _____ Insurance: When making an appointment with WFGIA, it is your responsibility to confirm with your insurance company that the physician is currently **in network** with your plan. If your plan requires a referral and you or your referring provider does not provide one by the scheduled appointment time, please be prepared to pay for your visit in full or reschedule. **Our office DOES NOT accept Medicaid.**

Initial _____ Check-in: Your time is very important to us. The first step in keeping your appointment on time is being prepared. This includes filling out all the required paperwork prior to your first appointment. This will avoid delays in creating your chart and account at your visit. Although we verify your coverage is active before your initial appointment, you must present your current insurance card along with a valid photo ID in order to verify your identity. This will insure all information is entered accurately and will prevent errors in filling out your claims. **All copays and/or deductibles will be collected at your visit. Patients without insurance coverage are required to pay office visits in full, not to exceed $360.00, unless prior payment arrangement was made in advance of the visit.**

Initial _____ Procedure Cancellation Policy: Procedures that are cancelled 48 hours or less will be subject to a $100.00 cancellation fee and **this fee must be paid before your procedure will be rescheduled.** Cancellations must occur on Monday – Friday during our business hours of 8am -5pm. Cancellations made on a Saturday or Sunday will not be accepted as part of the required time as our office is closed and staff will not be available. The patient must call our office and speak with your Dr's. surgery scheduler. Cancelling at the facility will not cancel for our office.

Initial _____ Changes in Coverage or Personal Information: It is the patients responsibility to make sure this office is aware of any changes in your insurance coverage and/or personal information in a timely manner. Many insurances have timely filing limits and if we cannot obtain payment for your services during the allotted time frame, the patient will be financially responsible for all charges incurred.

Initial _____ Patient Financial Responsibility: Ultimately, the patient is responsible for their account with our office, whether insurance pays or not. Patient balances over 60 days are due in full upon receipt of statement. Outstanding balances over 60 days with no payments or calls to make financial arrangements, may be referred to an outside agency for collections. The patient will be responsible for **all costs** associated with the collection of their account by a third party. Please note you may be dismissed from this practice due to non-payment of services.

I have read, understand and agree to the above office and financial policies.

Patient Name: _____ Date of Birth: _____

Please Print

Patient Signature: _____ Date: _____

Wichita Falls Gastroenterology Associates (WFGIA)

Initial _____ Consent for Treatment: By signing this consent I am authorizing my physician(s), known as Wichita Falls Gastroenterology Associates (WFGIA) to perform and/or order another person to perform all exams, tests, procedures, and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition. This consent is valid for each visit/telephone call made to WFGIA unless revoked by me orally or in writing.

Please be informed Texas law allows patient to be tested for possible exposure to the Human Immunodeficiency Virus (HIV), the virus associated with AIDS, in the following situations: 1) to screen blood, blood products, organs or tissues to determine suitability for donation; 2) if another individual is accidently exposed to a patient's blood or bodily fluids, such as through a needle stick (any such test shall be conducted pursuant to Ambulatory Services infectious disease protocol) or; 3) if a medical or surgical procedure is to be performed which could expose healthcare workers to the patient's blood or bodily fluids. This disclosure is to inform you that you may be tested if any of these situations occur during your treatment period.

Initial _____ Notice of Privacy Practices/Patient Rights and Responsibilities:
WFGIA Notice of Privacy Practices/Patient Rights and Responsibilities, which explains how my medical information may be used and disclosed is on display in the reception area for my review. I understand that I am also entitled to receive a copy of this document and can request a copy at any time. The date of the last revision of this policy was November 20, 2014.

Initial _____ Assignment of Insurance Benefits: I hereby authorize payment directly to WFGIA for all medical/surgical benefits which are reimbursed under my insurance policy(s). I hereby authorize to release any medical information that may be necessary to determine benefits or secure reimbursement. This authorization shall remain valid until written notice is given by me to revoking this authorization. I understand that I am financially responsible for all charges whether or not they are covered by my insurance. Any payments sent to the insured for services payable to WFGIA should be sent or signed over to WFGIA upon receipt.

Initial _____ Financial Interest Disclosure: The Doctors of Wichita Falls Gastroenterology have a financial interest in Wichita Falls Endoscopy Center.

_____ _____
Patient Name Date

_____
Date of Birth

_____
Patient Signature
(Please Print)

Wichita Falls Gastroenterology Associates
(WFGIA)

Permission to Disclose Relevant Health Information to Friends and Family

We value your privacy and ask that you help us identify the persons with whom you would like WFGIA to discuss your health care. (Including but not limited to: test results, recent visits, medication requests, appointment information, and billing/insurance information or in the event of an emergency.)

_____I hereby authorize Wichita Falls Gastroenterology Associates (WFGIA), to disclose relevant health information to my family members and/or to any individuals I have listed below:

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____ _____

Patient Name (Please Print) **Date of Birth** **Date**

Patient Signature:_____

This does not authorize copies of PHI to be released, mailed, or faxed to the person(s) listed. To obtain copies of PHI a valid HIPPA release is required.*

Wichita Falls Gastroenterology Associates

TCPA – EXHIBIT A

You agree, in order for us to service your account or to collect any amounts you may owe, we and our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you.

We may also contact you by sending text messages or e-mails, using any e-mail address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

I/We have read this disclosure and agree that the practice may contact me/us as described above.

_____

Print Patient Name

_____

Patient/Guarantor Signature

_____

Signature Date