Metro Atlanta Gastroenterology
Metro Atlanta Endoscopy, LLC

PLEASE PRINT

Last Name: _____ **First**: _____ **MI**: _____

Address: _____
Street City Zip Code

Home Phone #: _____ Cell Phone #: _____ Email_____

Birthdate _____ Sex: _____ Marital Status: _____ Race_____ Ethnicity_____ Language_____

Preferred method of contact (check one) Phone _____ Email _____ Postal Mail _____

Reason for Visit / Chief Complaint: _____

Referring Physician/PCP/Internist: _____ Phone: ( ) _____

Address: _____ Fax: ( ) _____

Insurance Information:

{Primary Insurance} Last Four Digits

Policy Holder: _____ Social Security #_____ Birthdate _____
Relationship: _____

Patient Employer:

Employer/Position: _____

Address: _____

City, State, Zip Code: _____

Spouse Information:

Name_____ Birthdate_____

Employer_____Work Phone_____Cell Phone_____

Emergency Contact:

Name: _____ Phone: _____ Relationship: _____

I authorize the release of any medical information, including information related to psychiatric care, drug and alcohol abuse and HIV/AIDs confidential information, necessary to process insurance claims or any medical information that is needed for any utilization review or quality assurance activities. I assign medical and/or surgical benefits to which I am entitled to the following physicians: Drs. Carson, Weinstein, Shapiro, and Curtis**. I understand I am fully responsible for all fees not covered by my insurance. In the event that my account is turned over to a collection agency, I understand and agree that I will be responsible for any collection fees (33.33%), reasonable attorney fees, court costs, etc.** This assignment will remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. I have received a copy of Metro Atlanta Gastroenterology & Metro Atlanta Endoscopy practice policies covering appointments, after hours, prescription and insurance responsibilities.

Signed (Patient or Parent if Minor) **Date**

5669 Peachtree Dunwoody Road NE, Suite 210 Atlanta, GA 30342 (404) 255-4333 / Fax: (404) 255-0601

Medications & Allergies

Please answer every question

*STAFF: ALL items in this form must be entered **MANUALLY**.*

Marking Instructions

Please use a #2 pencil.
Fill in the complete oval as shown...

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

ALLERGIES

Please mark any of these allergies you have:

I HAVE NO KNOWN MEDICATION ALLERGIES ◯

Contrast or Iodine Allergy ◯
Latex Rubber Allergy ◯
Anaphylactic or Other Reaction to Anesthesia ◯

MEDICATION ALLERGIES

Please list all medications or injections that have given you bad reactions.

If possible, include your reactions (e.g., hives, welts, rash, itching, headaches, nausea, diarrhea, passed out, shock, shortness of breath, etc.)

Medication or Injection	Reaction

Medication or Injection	Reaction

PRESCRIPTION MEDICATIONS

Please list all prescription medications you are currently taking.

(Alternatively, bring in an accurate list to your appointment.)

Name of Medication	Dosage	Frequency

Name of Medication	Dosage	Frequency

OVER-THE-COUNTER MEDICATIONS

Please list all over-the-counter medications you are currently taking.

(e.g., aspirin, Motrin, Tagamet-HB, vitamins, herbs, etc.)

Name of Medication	Dosage	Frequency

Name of Medication	Dosage	Frequency

PREFERRED PHARMACY

For technical support, please contact PatientLink at Support@MyPatientLink.com.

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I AUTHORIZE THE USE / DISCLOSURE OF HEALTH INFORMATION ABOUT ME AS DESCRIBED BELOW.

Patient Name:

Patient's Date of Birth: Contact#:_____

TO: _____FAX:_____

(PHYSICIAN'S NAME) FAX IS REQUIRED PLEASE

Please release my Protected Health Information to:Metro Atlanta Gastroenterology, LLC

FAX:404-255-0601ADDRESS:5669 Peachtree Dunwoody Rd., Suite 210, Atlanta, GA 30342

(Person(s) or Organization(s) authorized to receive the information)

Specific description of the information that may be used or disclosed

Office notes_____ EKG/Cardiac Tests_____Endoscopy Reports_____

X-Ray Reports_____ Lab Reports_____Pathology Reports:_____

All Records_____ Other_____

Specific description of how the information will be used: Medical Treatment

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1) I understand that this authorization will **not expire until I revoke my authorization.**
2) I understand that I may **revoke** this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying *(insert name of practice)* in writing.
3) I understand that I can **refuse to sign** this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits (if applicable).
4) I may **inspect or copy** any information used or disclosed under this agreement.
5) I understand that if the person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be redisclosed and would no longer be protected by these regulations.

YOU HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM

_____ _____

Patient's Signature or Patient's Representative Date

_____ _____

Printed Name of Patient's Representative Relationship to Patient

New Patient Consent to the Use and Disclosure of Health Information
for Treatment, Payment , or Healthcare Operations

*I understand that as p*art of my health care, Metro Atlanta Gastroenterology and Metro Atlanta Endoscopy originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

. A basis for planning my care and treatment,
. A means of communication among the many health professionals who contribute to my care,
. A source of information for applying my diagnosis and surgical information to my bill
. A means by which my insurance carrier can verify that services billed were actually provided, and
. A tool for routine healthcare operations such as assessing quality and reviewing the competence of Healthcare professionals

I understand and have been provided with a Notice of Privacy Policies that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

. The right to review the notice prior to signing this consent,
. The right to object to the use of my health information for directory purposes, and
. The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I further understand that Metro Atlanta Gastroenterology and/or Metro Atlanta Endoscopy reserve the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the code of Federal Regulations. Should the practice or endoscopy center change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email)

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

_____

I understand that Metro Atlanta Gastroenterology and/or Metro Atlanta Endoscopy Center is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.
I fully understand and accept/decline the terms of this consent.

_____ _____

Patient's Signature Date

HIPAA RELEASE OF MEDICAL RECORDS
TO DESIGNATED INDIVIDUALS

I hereby authorize one or all of the designated parties listed below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to the treatment and payment. I understand that the identity of designated parties must be verified before the release of any information. **Do not include physicians, or insurance companies, only family/friends.**

Authorized Designees:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

( ) I have had access to Metro Atlanta Gastroenterology's Privacy Policies and have been offered a copy for my records.

_____
Patient Name

_____
Patient Signature

_____
Date

**When leaving a message pertaining to your medical records, what is the best number with which to contact you.
_____**

Assignment of Benefits Form

I _____ (Print Name) with insurance benefits through (Employer Name) _____ (Medicare, Medicaid, or Individual Plan) as well as my governing Health and Welfare Plan or any Social Security Act, including title XVIII of the Social Security Act, hereby appoint as my authorized representative in connection with my claim for all medical services requested and rendered, as well as all entitled benefits and protected rights under my Plan or Policy related to all services rendered or requested. I authorize the above named provider or any appointed business associate acting under a valid business associate agreement to make any request for appeal on my behalf, present or to elicit evidence; to obtain all appeal correspondence and findings; and to receive all notifications in connection with my appeal, wholly in my stead. I understand that personal medical information related to my appeal may be disclosed to an appointed business associated to act on my behalf as my appointed authorized representative. I authorize all entitled benefits under my Plan/Policy to be paid directly to the provider listed above for all services rendered. I understand that I am entitled to all benefits that my Health and Welfare or Social Security Plan is legally obligated to provide, including any legal claim to benefits under the governing Plan. I understand that my Plan Sponsor and Health Insurance Issuer are required to accept and honor this agreement for all services rendered, in full compliance of all governing state and federal laws. This authorization includes any and all rights permissible under my governing Health and Welfare Plan; applicable Social Security Act; Federal, City or State Government program; as well as state and federal law related to all services rendered. I understand this authorization also covers any and all other providers of service directly associated with services rendered and requested by the above provider, including but not limited to all other providers involved with surgical related services, including surgical assistants, anesthesiology services, diagnostic testing, labs, pathology, radiology, implants, tissues, or any other services rendered or requested by the provider above and entitled under my governing or Federal covered health Plan. I appoint and authorize the above provider and business associate appointed by the provider as my duly authorized and personal representative relating to all services rendered, rights of appeal, disclosure and remedies due me under law. I hereby certify that all insurance information provided is true and accurate and that I am responsible for keeping it updated. I understand that failure to provide accurate insurance information and coordination of benefit coverage at time of service or any failure to cooperate with the provider to the fullest extent to obtain full entitled reimbursement for all services rendered will result in my full financial responsibility of all services rendered. I hereby authorize the Provider listed above to submit claims, on my behalf, to the insurance company responsible for administering entitled benefits for all services rendered. I fully agree and understand that the submission of a claim does not absolve me of my responsibility to ensure the claim is paid in full and in full compliance of applicable state and federal laws. I also understand I may be responsible for any and all amounts not payable by my insurance company including any portion paid and not applied to in network benefits for any out of network services, non covered services, services determined by the insurer as not medically necessary, or any failure by my insurer to comply with all governing and applicable laws. I agree to cooperate with all providers listed in this agreement in any attempts by such provider to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with provider against such insurers and/or employee health care plan for failure to pay all entitled benefits or provide all protected rights.

Thereby irrevocably, designate, authorize and appoint the Provider listed above or any appointed business associate as assigned by the provider as my true and lawful attorney-in-fact. This power of attorney is hereby provided for the limited purpose of assuring receipt of all entitled benefit payments, rights of appeal, disclosure and remedies due under my governing Health and Welfare or Federal Healthcare plan or Policy to include all medical services rendered or to be rendered as ordered by the provider listed above. This power of attorney shall automatically terminate, without formal action being taken, as soon as the above listed healthcare provider/s has received payment in full and all rights as entitled under my governing Plan and in full compliance of governing federal and state laws. I hereby confirm and ratify all actions taken by my attorney-in-fact pursuant to the authority granted herein. I hereby authorize my Plan and insurer unequivocal assignment and transfer of all entitled plan benefits, all rights under the Plan and federal law of appeal, disclosure, remedies and litigation due me to the Provider listed above and any appointed business associates working with them for the sole purpose of making sure all entitled benefits and rights under my specific health and welfare plan of governing law are administered in full compliance and to the extent of governing law. This authorization includes all protected rights under applicable governing law to receive entitled benefits, submittal of evidence, receive requested disclosures, to give or receive any notice related to benefits and rights, receive copies of all relevant documents and data pertaining to my claim and appeal submittals, receive governing plan documents, remedies, request administrative reviews, litigation, or make any statement of fact and law on my behalf to the extent consistent with Federal and state law. This is a direct unequivocal assignment of all rights and benefits under the governing plan/policy/Social Security Act. I understand this payment will not exceed my indeptedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment where entitled benefits applicable to governing federal and state laws are paid. I hereby instruct and direct my Plan or Health Insurance Issuer to pay all entitled plan benefits as required by the governing Plan/Policy directly to any applicable Provider(s) listed above following all terms, conditions and requirements of the governing Health and Welfare Plan. I understand under applicable governing law that I have the right and authority to direct where payment for services rendered is sent. If my current policy prohibits direct payment to the provider of service, I under my protected rights pursuant to applicable state, federal or ERSIA law hereby instruct and direct my Insurance Company to provide specific SPD documentation stating such non-assign ability clause to myself and the applicable Provider, along with the regulatory guideline that allows for such non-assignability. Upon proof of specified non-assignability documentation, I then instruct that the insurer make the check out to me and mail it directly to the Provider and address listed on the submitted claim for the professional or medical expense benefits, and otherwise payable to me under my current insurance policy as payment towards the total charges for the professional services rendered. I agree and understand that any funds received by my insurance company due for services rendered by any and all healthcare providers listed in this assignment of benefits will be immediately signed over and sent directly to such provider. Upon receipt of said check, I authorize Provider listed above to receive any such checks, endorse them for deposit only, and to deposit and apply all proceeds toward payment due on my account. I authorize the release of any information pertinent to my case including any and all medical records required for a full and fair review to any business associate, insurance company, adjuster, Plan Sponsor, Plan Administrator, governmental agency or attorney involved or responsible for making sure all protected rights and entitled benefits are provided. I authorize duly authorized representative to initiate formal complaints to any State or Federal agency that has jurisdiction over my insurer and/or plan benefits. Should the account be referred to an attorney or outside agency for collection, the undersigned shall pay reasonable attorney's fees and collection expenses. I understand that all delinquent accounts bear interest or administrative fees at the legal rate. I also agree that any penalties or fines levied against my insurance company will be paid to the Provider acting as my personal representative. I understand that this assignment will remain in effect until revoked by me in writing except to the extent that the covered entity has already used or disclosed information under the authorization or (b) if the authorization was obtained as a condition of insurance coverage, or other law that provides the insured with the right to contest a claim under the governing Plan/policy. A photocopy of this Assignment shall be considered as effective and valid as the original.

_____ _____ _____

Signature of Patient/Guarantor Full Address (Required by Some Insurance Plans) Date