Digestive Healthcare of Georgia, P.C.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name: _____

DOB:_____/_____/_____ **Social Security #:**_____/_____/_____

I understand that, as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plan for future care or treatment. I hereby give my consent for Digestive Healthcare of Georgia, P.C. to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). I have been given the opportunity to read the "Notice of Privacy Practices" which provides a more complete description of such issues and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing the consent. Digestive Healthcare of Georgia reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Digestive Healthcare of Georgia Privacy Officer at 3280 Howell Mill Road N.W., Suite T100, Atlanta GA 30327.

I reserve the right to restrict information, medical or financial, that Digestive Healthcare of Georgia is authorized to release and/or designate specific individual/entities authorized and/or discuss the information regarding my care. If I choose to restrict the release of information and/or the individuals/entities that may receive this information from Digestive Healthcare of Georgia, I may do so by completing the "Authorization to Restrict/Release Personal Health Information" form that will be placed in my permanent chart.

With this consent, Digestive Healthcare of Georgia may call my home or other alternative location as specified by me, and leave a message in person or on voice mail regarding any items that assist the practice in carrying out TPO, such as appointment reminders, insurance inquiries/information, and/or calls pertaining to my clinical care, including test results (laboratory, X-rays, etc.).

I may revoke this consent in writing to the extent the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Digestive Healthcare of Georgia may decline to provide treatment to me. By signing this form, I am consenting Digestive Healthcare of Georgia's use and disclosure of my PHI to carry out TPO as permitted by the Health Information Portability and Accountability Act (HIPAA)

I understand that information contained in my medical chart serves as:

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

_____ _____/_____/_____

Signature of Patient, Guardian or Legal Representative Date

_____ _____/_____/_____

Witness Signature Date

Digestive Healthcare of Georgia, P.C.
Disclosures to Family Members Policy

Patient Name: _____ DOB _____

Digestive Healthcare of Georgia (DHC) has adopted the Disclosures to Family Members Policy to comply with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA), as amended by the HITECH Act, the Department of Health and Human Services ("DHHS") security and privacy regulations, and the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO") accreditation standards, as well as it being our duty to protect the confidentiality and integrity of confidential medical information as required by law, professional ethics, and accreditation requirements.

To ensure Digestive Healthcare of Georgia, P.C. meets the guidelines of the Disclosures to Family Members policy, we would like to reassure that the family members and/or close personal friends with whom the patient would like to share PHI ("Protected Health Information") is relevant to that individual's involvement with the patient's care. Anyone whom the patient allows to be a part of their PHI will also be able to hear the physician's results after the patient's procedure.

Please select one of the following:

☐ **I AUTHORIZE** disclosing my health information to:

Name: _____/Relationship_____

Name: _____/Relationship_____

☐ **I DO NOT AUTHORIZE** disclosing my health information.

☐ **I ONLY AUTHORIZE** disclosing my health information to the following person(s)/entities:

_____

_____

_____

Please note which phone numbers we MAY leave a DETAILED voice mail message:

☐ **Home** ☐ **Cell/Mobile Phone** ☐ **Work** ☐ **NONE** (*Do not leave voicemail messages on any number I have provided.*)

_____ _____

Patient/Guardian Signature Date

DIGESTIVE HEALTHCARE OF GEORGIA, P.C.
Patient Financial Responsibilities
(**Please bring this signed form with you to your appointment**)

Digestive Healthcare of Georgia welcomes you to its family of physicians and healthcare providers. We are pleased you have chosen us to care for you and we commit to enhance the value and quality of your care. This policy statement is intended to answer questions you may have regarding payment for services rendered at our facilities or in the hospital setting by members of the group. Your questions and comments are welcomed.

While we hope to maintain a longstanding relationship with you, we must ensure all patients follow our policies. We require all our patients to read and sign this document and we will maintain this in our files. Failure to adhere to these financial policies can result in dismissal from the practice.

Payment for Services

For your convenience, we accept cash, VISA, MasterCard, and AMEX, debit cards, traveler's checks, money orders and personal checks. Starter checks and postdated checks are not accepted. A valid picture ID is required on all checks. **If co-payments, coinsurances and/or deductibles are required by your insurance plan, they are due when services are rendered.**

Cancellation/No Show Policy

To ensure that all our patients have access to our physicians, we have established the following fees for late cancellations and no shows. Office visits cancelled less than 24 hours of the appointment may be subject to a charge of $50.00. Procedures cancelled less than 72 hours of the appointment may be subject to a charge of $250.00. These charges will be billed to the patient and not their insurance carrier.

Late Arrivals

Patients who arrive more than 15 minutes late for a scheduled appointment may be asked to reschedule. Your provider will determine if he/she is able to work in your appointment if time allows.

Please be aware that there will be a wait associated with being worked back in to the schedule. If the provider is unable to work the appointment into their schedule you will be asked to reschedule.

Self-Pay Patients

The group welcomes self-paying patients when no insurance coverage is available for our services. Patients who have no insurance are asked to pay in full at the time of service. If for any reason you may be unable to pay in full at the time of service, speak with the billing manager in advance of the visit to determine if reasonable payment arrangements can be established with the group. Patients without insurance are required to pay a $100 retainer when checking in. This will be applied towards your visit. If your visit is more than $100, you will be billed the remainder of your balance. All lab tests are a separate fee through LabCorp. Fees for your labs will be due at time of service.

Filling out Forms

For your convenience, our physicians will fill out FMLA forms for our patients. The fee for this service is **$30.00**. This fee must be paid when the form is mailed or dropped off at the practice. Patients are not required to pay a fee for State disability or Workers Compensation forms.

Insurance Coverage

Your Physician's Participation with Your Insurance Plan

Our group accepts most major insurance plans. Prior to your initial visit, please contact your insurance carrier to confirm that the physician you'll be seeing participates in your plan. If a procedure is necessary and you decide to have your procedure performed in our endoscopy lab, contact your insurance carrier to ensure that our endoscopy lab is also in network with your insurance plan. Our billing department will assist you with any information your insurance carrier may need to clarify our physician/endoscopy lab's participation with your plan.

If the physician does-not participate with your insurance plan, you will be responsible for payment of all charges at the time of your visit. You will be provided an itemized bill which you may submit to your insurance plan for any reimbursement for which you may be eligible.

Current Insurance and Patient Demographic Information

If your physician participates with your insurance plan, we will file a claim on your behalf and only request payment at the time of service for any co-payments, deductibles, coinsurances or services that are not covered by your plan. For the group to file your insurance, we must have a valid picture ID, the current insurance coverage(s) and be made aware of any changes in either insurance or patient address or phone numbers. **Please bring your insurance card to every visit so that we can confirm your coverage. Otherwise, the visit will be considered self-pay.**

Patient Payment Responsibility for Non-Covered Services

In some cases, your insurance may not cover certain services or may have coverage limits in place. Limited coverage on routine, preventive healthcare is common among insurance plans. We may request payment for any known, non-covered services at the time of your visit; otherwise they will be billed to you at a later date.

Managed Care Insurance (HMO. POS &PPO plans)

Patients with managed care health plans will be expected to follow the payment-at-time-of service requirements of the particular plan under which they are covered. Managed care patients will not receive monthly statements except for services that are not covered by the plan.

Your managed care plan may require a **referral** from your PCP in order to pay for your visit to a specialist. Please make sure you have obtained any required referrals in advance of your visit. If your insurance plan requires a referral and we do not have one, we will try to notify you prior to the visit. If we are unable to obtain a referral while you wait, you will be given the option to pay for the visit out of pocket or to reschedule the visit for a later date after the referral can be obtained.

Your managed care plan may also require **prior authorization (precertification)** prior to any outpatient procedures performed by our physicians. Our precertification department will assist in obtaining prior authorization for outpatient services that are considered medically necessary. However, **Screening Colonoscopy** may not be covered by your insurance plan even if it is recommended by your physician. You are responsible for calling your insurance carrier to ensure that **routine colonoscopy screenings** are a covered benefit under your insurance plan.

Indemnity Insurance

Our group does not contract with indemnity insurance plans, with the exception of Blue Cross. All other indemnity plans will be filed as a courtesy by our office. If payment is not received within 60 days from the time the claim is filed, the visit will be changed to self-pay status.

Medicare Insurance

Our physicians accept Medicare assignment on covered Medicare charges. Payment for the 20% Medicare coinsurance amount will be billed after we receive payment from Medicare. Payment of the annual deductible or any non-covered charges is expected at the time of service unless you have secondary insurance accepted by the group (see "Secondary Insurance" policy below).

Medicare may not pay for certain services it determines to be medically unnecessary. If there is a possibility that a service to be provided to you may fall into this category, you will be asked to sign an **advanced beneficiary notice** indicating that you acknowledge this possibility and that you agree to pay for all services Medicare determines to be medically unnecessary.

Medicaid & Georgia Better Healthcare Insurances

Patients must show proof of current Georgia Medicaid eligibility (current Medicaid card or DMA964 form) prior to seeing a physician. Co-payments are to be paid at the time of service.

Worker's Compensation Insurance

Validated worker's compensation services are billed either to the employer or the employer's carrier, depending on company policy. In the absence of validation by the employer of a work related injury, the patient will be held responsible for payment for services rendered. Should the employer or carrier subsequently deny a validated workers compensation service, such charges will be the financial responsibility of the patient.

Secondary Insurance

We file secondary insurance only for plans accepted by the group. We also file all Medigap insurance plans for our Medicare patients. We allow 60 days from the date of service for your secondary payer to pay. Beyond 60 days, unpaid secondary balances are patient responsible.

Signed: _____ Date: _____

Patient/Guarantor

By signing above, the patient or guarantor acknowledges that he/she has read and agrees to comply with all policies above. Please bring this signed form to your appointment.