DIGESTIVE DISEASE GROUP PA

103 LINER DRIVE | Greenwood, SC 29646
PHONE: 864-227-3636 | FAX: 864-227-6116
OFFICE@DIGESTIVEDISEASEGROUP.COM

Welcome to Our Practice

Thank you for choosing Digestive Disease Group. We realize that you have many options when it comes to providers, and we are please that you have chosen us to care for your needs. We are committed to providing you with high quality care and a comfortable experience.

Our forms are available online at www.digestivediseasegroup.com. You may print and bring them along with you to save time, or fax or email them ahead of your appointment.

On your first visit you can expect:

- An introduction to our office and staff
- A thorough examination and review of your needs
- A discussion of the most satisfactory treatment plan options for your health goals

As a convenience to you, our office will bill your insurance. We will do everything we can to make sure that you receive the maximum benefit from your insurance plan. Please remember that your insurance may not cover all costs.

Please note, you will receive two (2) charges for services performed at The Greenwood Endoscopy Center. The first is a professional fee from the physician performing the procedure. You will also receive a separate bill for a facility fee to cover the cost of the equipment and supplies.

Patient service is a priority in our practice. We recognize the value of your time. Except in emergency situations, you can expect us to be on time for you. We would appreciate the same courtesy. If you are unable to make your appointment please let us know as soon as possible. There may be a charge for missed appointments or if a 48 hour cancellation is not received.

If you have any questions regarding our procedures or services, please feel free to contact us. We will be pleased to assist you in any way possible.

We look forward to seeing you soon!

Sincerely,

A. A. RAMAGE III, MD • W. J. GILCHRIST, MD • M. S. Z. BACHINSKI, MD
B. T. GREEN, MD • R. SADURSKI, MD • H. B. KINDARD III, MD (1948-2000)

DIGESTIVE DISEASE GROUP, PA
103 LINER DRIVE
GREENWOOD, SC 29646-2311
(864) 227-3636

THE GREENWOOD ENDOSCOPY CENTER, INC
103 LINER DRIVE
GREENWOOD, SC 29646-2311
(864) 227-3838

ACCOUNT # _____ *PHYSICIAN* _____

PATIENT NAME _____ *MAIDEN NAME* _____

ADDRESS _____ *CITY* _____

STATE _____ *ZIP CODE* _____ *COUNTY* _____ *EMAIL* _____

HOME PHONE # _____ *WORK PHONE #* _____ *CELL PHONE #* _____

BIRTHDATE _____ *SOCIAL SECURITY #* _____ *M* _____ *F* _____

MARITAL STATUS - M S SP D W RACE – CAUCASIAN AFRICAN AMERICAN ASIAN INDIAN HISPANIC OTHER

EMPLOYER & ADDRESS _____

PERSON RESPONSIBLE FOR PAYMENT, RELATIONSHIP, & ADDRESS IF NOT PATIENT _____

_____

PRIMARY INSURANCE COVERAGE

NAME OF PRIMARY INSURANCE _____

PRIMARY INSURANCE ADDRESS _____

POLICY NUMBER _____ *GROUP NUMBER* _____

NAME OF INSURED AND DATE OF BIRTH (If other than Patient) _____

PLACE OF EMPLOYMENT (If applicable) _____

RELATIONSHIP TO PATIENT (If other than Patient) _____

SECONDARY INSURANCE COVERAGE

NAME OF SECONDARY INSURANCE _____

SECONDARY INSURANCE ADDRESS _____

POLICY NUMBER _____ *GROUP NUMBER* _____

NAME OF INSURED AND DATE OF BIRTH (If other than Patient) _____

PLACE OF EMPLOYMENT (If applicable) _____

RELATIONSHIP TO PATIENT (If other than Patient) _____

OTHER INSURANCE COVERAGE

NAME OF OTHER INSURANCE _____

OTHER INSURANCE ADDRESS _____

POLICY NUMBER _____ *GROUP NUMBER* _____

NEXT OF KIN _____ *RELATIONSHIP TO PATIENT* _____

ADDRESS _____ *CITY* _____ *STATE* _____ *ZIP* _____

HOME TELEPHONE NUMBER _____ *WORK TELEPHONE NUMBER* _____

REFERRING PHYSICIAN _____ *PRIMARY PHYSICIAN* _____

PHARMACY NAME, ADDRESS, & PHONE NUMBER _____

PLEASE COMPLETE BOTH SIDES OF FORM, SIGN AND DATE

Verifying Employee's Initials & Date

_____

DIGESTIVE DISEASE GROUP, PA AND THE GREENWOOD ENDOSCOPY CENTER INC

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Digestive Disease Group, PA (DDG) and/or The Greenwood Endoscopy Center, Inc (GEC) to use and disclose protected health information about me to carry out treatment, payment, and healthcare operations. The Notice of Privacy Practices provided by DDG and GEC describes such uses and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing consent. DDG and/or GEC reserves the right to change its' Notice of Privacy Practices at any time. A copy of this notice has been provided to me.

With this consent, DDG and/or GEC may call my home or other alternative location and leave a message on my answering machine or in person in reference to any items that assist the practice or center in carrying out treatment, payment, and healthcare operations. This may include appointment reminders, insurance items and any calls pertaining to my clinical care including laboratory tests and biopsy results among others.

With this consent, DDG and/or GEC may mail to my home or other alternative location any items that assist the practice or center in carrying out treatment, payment, and healthcare operations. This may include appointment reminder cards, recall letters, and patient statements.

With this consent, DDG and/or GEC may e-mail to my home or other alternative location any items that assist the practice or center in carrying out treatment, payment, and healthcare operations. This may include appointment reminder cards, recall letters, and patient statements.

I have the right to request that DDG and/or GEC restrict how it uses or discloses my protected health information to carry out treatment, payment, and healthcare operations. The practice and/or center are not required to agree to my requested restrictions, but if it does, it is bound by this agreement. I have the right to a list of the disclosures made by DDG and/or GEC of my protected health information.

By signing this form, I am consenting to allow DDG and/or GEC to use and disclose my protected health information to carry out treatment, payment, and healthcare operations. I hereby assign to DDG and/or GEC all payment for medical services rendered to me or my dependents. I understand that I am responsible for any amount not covered by my insurance. I also understand that a prompt refund will be given for my overpayment.

I may revoke my consent in writing except to the extent that the practice and/or center have already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, DDG and/or GEC may decline to provide treatment to me.

Signed by: _____
Signature of Patient or Legal Guardian

_____ _____
Date ***Relationship to Patient***

_____
Print Patient's Name

_____
Print Name of Legal Guardian if applicable

Ways in which we may reach you. Remember, we may need to reach you promptly regarding your appointment or issues that may affect your health.

(If same as listed on front, you may write "same.")

Home Phone:_____ ***Work Phone:***_____ ***Ext:***_____ ***Mobile Phone:***_____

Mailing Address:_____

E-mail:_____

May we leave a message on your answering machine? Yes No May we leave a message at the phone number(s) listed above? Yes No

May we leave normal results (for example normal lab, biopsy, x-ray, etc) on an answering machine? Yes No

May we speak with your spouse? Yes No Name:_____ ***Contact number:***_____

Please list other individuals with whom we may discuss your health or medical care, please include their phone numbers:

_____

_____

<u>Advance Directives:</u> You have the right to bring a copy of your Advance Directive, such as a living will or durable power of attorney for health care with you, but we do not formulate these. S.C. law establishes a priority list of relatives who may consent to treatment if you are unable to do so yourself. You have the right, by formulating a durable power of attorney for health care, to both supplant that priority list and to give your agent or surrogate, broader authority to act in your behalf with respect to health care matters. You may be asked about advance directives during pre-admission or at admission for your procedure, however The Greenwood Endoscopy Center does not honor advance directives in the event of deterioration or medical emergency.

Advance Directives: YES NO _____ ***If yes, are you providing us with a copy? YES NO*** _____
Patient Initials ***Patient Initials***

DIGESTIVE DISEASE GROUP PA

Disclosure/Agreement

Date: _____ Name: _____

MR# _____ Date of Birth: _____

Reason for today's visit:

☐ Routine Preventive Exam (I have no medical complaint or significant problem/abnormality that I am aware of)

☐ I have a problem/complaint that I wish to have evaluated/treated by the doctor. My chief complaint is:

_____

_____

☐ My insurance plan covers Preventive Medical Services

☐ My insurance plan does not cover Preventive Medical Services

☐ I do not know if my insurance plan covers Preventive Medical Services

I agree to pay for any and all medical services I receive from the doctors/providers of this practice that my insurance company refuses to pay, for whatever reason. This office will file a claim in my behalf, however, if my insurance company refuses to pay, for whatever reason (e.g., non-covered services, does not pay for preventive medicine visits, my failure to secure a referral from my primary care physician), I will pay for same upon written/verbal notice of their refusal. Failure to pay within 45 days of filing is, for the purpose of this agreement, a refusal to pay.

I further agree and understand that this office can only code and file a claim for my visit(s) with a diagnosis that was encountered and documented in my medical record. Thus, to ask this office to change a diagnosis code solely for the purpose of securing reimbursement from any insurance carrier is inappropriate and may result in a fraudulent act(s).

In the event I do not pay for these or any other services provided me when due, I agree to pay all cost of collection, including reasonable attorney fees, whether or not a lawsuit is commenced as part of the collection process.

By: _____ Witness: _____

Patient or Responsible Party if Minor

Patient Rights

All patients who receive services through The Greenwood Endoscopy Center, Inc. or its affiliates have inherent legal and moral rights. These rights include confidentiality, timely information, dignified care, respect for personal values and beliefs, and personal safety. Reasonable attempts will be made for staff to communicate in the language or manner primarily used by the patient. Responsibilities include following the rules and regulations of the ASC, providing accurate information, following treatment and fulfilling obligations. *It is the policy of The Greenwood Endoscopy Center, Inc. to honor in accordance with law each adult patient's or surrogate's right to make decisions regarding treatment, including the right to consent to, refuse or alter treatment plans. Advance directives are NOT honored at The Greenwood Endoscopy Center in the event of deterioration or medical emergency nor are they formulated.*

Patients have the right to:

- **COURTESY: As a patient, you deserve fair, considerate and humane care. You will not be denied necessary medical care that is within the capabilities of The Greenwood Endoscopy Center. You have the right of respect for your personal property.**
- **DECIDE: You have the right to be kept informed of your medical condition and treatment options. You have the right either to agree to the treatment or refuse the treatment (as long as the law permits such refusal) and to refuse any experimental treatment, drugs, or participation in research.**
- **PRIVACY: Physicians and other health care providers should discuss your medical history and treatment only with you or other people designated by you and with other providers involved in your care. You have the right to privacy while being treated and while receiving care.**
- **COMPLAINTS: You and your family have the right to make complaints regarding your care or treatment which will not affect your access to care. Every attempt will be made to address complaints/grievances within three working days.**
- **ADVANCE DIRECTIVES: You have the right to bring a copy of your advance directives such as living will or durable power of attorney for health care with you to GEC; GEC does not formulate these or honor advance directives, however. South Carolina law establishes a priority list of relatives who may consent to treatment if you are unable.**
- **KNOW: You have the right to know the identity of the health care team members who are caring for you. You have the right to change your physician.**
- **EDUCATION: You have the right to understand what treatment or procedure you are having.**
- **INFORMATION: You may at any time request complete information on your bill and will receive necessary explanation of charges.**
- **PERSONAL SAFETY: You have the right to receive care in a safe setting and to be free from all forms of abuse or harassment. You have the right of freedom from mental and physical abuse and/or exploitation.**

Office of the Medicare Beneficiary Ombudsman:

www.medicare.gov/ombudsman/activities.asp

If you have any questions, concerns or complaints concerning your medical information, care, or treatment you may contact: The Privacy Officer, 103 Liner Drive, Greenwood, SC 29646. Telephone: 864-227-3636. You may also contact: Division of Health Licensing, 2600 Bull Street, Columbia, SC 29201-1708 Telephone: 803-545-4370

FINANCIAL/COLLECTION POLICY

Digestive Disease Group, P.A.
The Greenwood Endoscopy Center, Inc.
103 Liner Drive, Greenwood, SC 29646
Ph (864) 227-3636 Ph (864) 227-3838
Fax (864) 227-6116

This is an agreement between Digestive Disease Group/Greenwood Endoscopy Center, as Creditor, and the Patient/Debtor named on this form:

By executing this agreement, you are agreeing to pay for all services that are received.

Monthly Statement:
If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, and any payments or credits applied to your account during the month.

Payments:
Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month.

Charges to Account:
We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service.

Required Payments:
Any co-payments required by an insurance company must be paid at the time of service. Because this is an insurance requirement, we cannot bill you for these.

Payment Options if you have NO insurance or Large Deductibles:
You may choose to pay by **CASH**, **CHECK**, or **CREDIT CARD** on the day that the appointment is scheduled. If you are unable to pay balance in full, we will accept a down-payment of **$75.00** on office visits, **$150.00** on consultations, and **$500.00** on procedures and will set up monthly payments equal to **10%** of the remaining balance.

Payment Option if you have Insurance:
You may choose to pay your deductible in full, and any out of pocket portions at the time services are rendered

by **CASH**, **CHECK**, or **CREDIT CARD.**

Overpayments:
In the event of an overpayment or error in payment processing on your account, a refund will be normally be issued within 60 days.

Insurance:
Insurance is a contract between you and your insurance company. We are **NOT** a party to this contract, in most cases. We will bill your primary and secondary insurance companies as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from your insurance company.

Divorce :
In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a minor child will be the parent responsible for those subsequent charges. If the divorce decree required the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Past Due Accounts :
If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you may receive calls from a collection agent or by automation and you agree to pay all of the collection costs which are incurred. If we have to refer collection of this balance to a lawyer, you agree to pay all lawyer fees which incur plus all court costs. In case of suit, you agree the venue shall be in Greenwood, County, South Carolina. If your account remains past due, you may be required to pay the entire balance in full before scheduling any further appointments.

Missed Appointment Fee :
If a patient does not show up for a scheduled appointment, or cancels with less than 24 hours notice for office appointments or 48 hours on procedure appointments a fee will be charged. A fee of $25.00 will be charged for office appointments. A fee of $50.00 will be charged for consultation appointments. A fee of $100.00 for a colonoscopy or upper endoscopy procedure. This fee must be paid before a new appointment is scheduled. Patients with more than (2) missed appointments will be seen only after approval from the attending physician.

Wavier of Confidentiality :
You understand if this account is submitted to an attorney or collection agency, if we have a litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you have received treatment at our office may become a matter of public record.

Co-Signature :

If this or another Financial Policy is signed by another person, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

Effective Date :
Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Print Patient's Name:_____ Responsible Party: _____

Patient's Signature:_____ Date:_____

DIGESTIVE DISEASE GROUP PA

Name: _____ **Account #** _____

Medication History Consent (Review of your prescriptions for the past year**)**

☐Grant ☐Decline

Race

☐ American Indian ☐ Alaska Native ☐ Asian ☐ Black ☐ African American ☐ Hispanic

☐ Native Hawaiian ☐ White ☐ Other Pacific Islander ☐ Other ☐ Unknown ☐ Declined

Ethnicity

☐ Hispanic ☐ Latino ☐ Non Hispanic ☐ Unknown ☐ Declined

Clinical Summary (If yes, you may pickup a copy at our office 72 hours after your visit)

☐ Yes ☐ No ☐ Save in Chart

Reminders (Check one; please note that automated reminders go to the # you list as home)

☐ Yes ☐ No ☐ Save in Chart

Pharmacy

Name	Address, City, State and Zip	Phone Number

Mail Order Pharmacy

Name	Address, City, State and Zip	Phone Number

Associate Providers (Primary, Surgeon, etc)

Name	Address, City, State and Zip	Phone Number