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

PATIENT NAME _____ *MAIDEN NAME* _____

ADDRESS _____ *CITY* _____

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

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

(PLEASE CIRCLE PREFERRED METHOD OF CONTACT ABOVE)

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

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* _____

*EMERGENCY CONTACT*_____ *RELATIONSHIP TO PATIENT* _____

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

HOME TELEPHONE NUMBER _____ *WORK TELEPHONE NUMBER* _____

REFERRING PHYSICIAN _____ *PRIMARY PHYSICIAN* _____

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 Account # _____

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 mail to my home or other alternative location, may email my specified email address and or call my home or other specified number, including my cell number and leave a message in reference to any items that assist the practice or center in carrying out treatment, payment and healthcare operations. This may include automated appointment reminders, insurance items and any calls pertaining to my clinical care including laboratory tests and biopsy results among others. This may also include contact by a Third Party Collection Agency should my account be assigned to collections if delinquent or past due.

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.

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***