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* ____________________________________

HOME TELEPHONE NUMBER ___________________________ *WORK TELEPHONE NUMBER* __________________________

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 ____________________________
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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

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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***

____

Print Patient's Name

_________________________ _________________________

Date *Relationship to Patient*

____

Print Name of Legal Guardian if applicable

_________________________ _________________________

Date *Relationship to Patient*

____

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:

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Advance Directives: 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 _______________________
Patient Initials