SKYLINE Gastroenterology of West Tennessee
powered by OneGI

PATIENT DEMOGRAPHICS INFORMATION

Please Print Legibly & Complete All Information

PATIENT INFORMATION

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

Race: [ ] Caucasian [ ] African-American [ ] Asian [ ] Hispanic or Latino [ ] Other _____

Social Security # ___-___-___ **Date of Birth (DOB)** _____ **Circle One:** Male / Female

Address _____ **City** _____ **State** _____ **Zip** _____

Cell Phone _____ **Home Phone** _____ **Work Phone** _____

Email Address _____

Preferred Method of Contact: [ ] Phone [ ] Email [ ] Patient Portal

Are You a Full-Time Student? [ ] Yes [ ] No **Are You Employed**: [ ] Full-Time [ ] Part-Time [ ] Retired

Employer Name & Address _____

Primary Care Physician _____

Preferred Pharmacy (Name & Location) _____

SPOUSE INFORMATION *(if applicable)*

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

Social Security # ___-___-___ **DOB** _____ **Circle One:** Male / Female

Cell Phone _____ **Home Phone** _____ **Work Phone** _____

Employer Name & Address _____

INSURANCE COVERAGE INFORMATION – Complete section below regarding person responsible for insurance coverage.

PRIMARY COVERAGE:

Name on Card _____ **DOB** _____ **Relationship to Patient** _____

Insurance Name _____ **SUBSCRIBER ID #** _____

SECONDARY COVERAGE:

Name on Card _____ **DOB** _____ **Relationship to Patient** _____

Insurance Name _____ **SUBSCRIBER ID #** _____

EMERGENCY CONTACT – Name of person to contact in case of an emergency, other than spouse.

Name _____

Relationship to Patient _____ **Phone #** _____

I hereby authorize payment of medical benefits billed to my insurance to Skyline Gastroenterology of West TN of West TN. I hereby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I accept responsibility for fees that exceed the payment made by my insurance, if the Practice does not participate with my insurance. I understand that in the event of default in payment of any amount due and if this account is placed with a collection agency or an attorney for collection or legal action, there will be an additional charge equal to the cost of collection, including the collection agency fee, attorney fee and/or any court costs incurred. I agree to pay all co-payments, coinsurance and deductibles at the time service is rendered. I agree that any overpayment will be automatically applied for any current balance due to Skyline Gastroenterology of West TN or the Skyline Endo Surgery Center facility charge prior to a refund being given to me. I also authorize Skyline Gastroenterology of West TN to leave information regarding my care at the contact info provided above via voice or text communication.

_____ _____

Signature of Patient or Guardian *Date*

PATIENT CONSENT FOR RELEASE OF INFORMATION

Please Print Legibly & Complete All Information

This form is required by the federal government.

I, _____, hereby authorize **Skyline Gastroenterology of West TN** to disclose my health information, which specifically identifies me, or which can reasonably be used to identify me, to carry out my treatment, payment, and health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, **Skyline Gastroenterology of West TN** can refuse to treat me.

I have been informed that **Skyline Gastroenterology of West TN of West TN** has prepared a notice ("Notice") which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment, and health care operations. I have the right to obtain a paper copy upon request.

I understand that I may revoke this consent at any time by notifying **Skyline Gastroenterology of West TN** in writing, but if I revoke my consent, such revocation will not affect any actions that **Skyline Gastroenterology of West TN** took before receiving my revocation.

I understand that **Skyline Gastroenterology of West TN of West TN** has reserved the right to change his/her privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request that **Skyline Gastroenterology of West TN of West TN** restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment, or health care operations. I understand that **Skyline Gastroenterology of West TN** does not have to agree to such restrictions, but that once such restrictions are agreed to, **Skyline Gastroenterology of West TN** must adhere to such restrictions.

I acknowledge and agree that **Skyline Gastroenterology of West TN** and any affiliate or vendor thereof, including collection or billing companies, may contact me by telephone or text message to any phone number I have provided to you, and any other phone number associated with my account, including wireless or mobile phone numbers. I further agree that you may use any method of contact to these numbers provided, such as an Automated Telephone Dialing System (ATDS) or prerecorded message. I also agree that I will notify **Skyline Gastroenterology of West TN** if I have given up ownership or control of any such telephone number.

HIPAA Privacy Notice / Patient Rights / Advanced Directive

I hereby acknowledge that a copy of the Notice of Privacy Practices for **Skyline Gastroenterology of West TN** has been made available to me. I have the right to obtain a paper copy upon request.

I have received written and verbal notification regarding my patient rights prior to my procedure. I have also received information regarding **Skyline Gastroenterology of West TN** policies pertaining to advanced directives. Advanced Directives will not be honored within this office.

_____ _____ _____

Signature of Patient or Patient Representative *Date of Birth* *Date*

_____ _____

Print Name of Patient or Patient Representative *Relationship to Patient*

RELEASE OF MEDICAL & BILLING INFORMATION

I, _____, authorize the physicians and staff of **Skyline Gastroenterology of West TN** to release information on file regarding my medical treatment and billing account to the person(s) listed below:

Name _____ Relationship to Patient _____

Name _____ Relationship to Patient _____

Name _____ Relationship to Patient _____

I understand that by signing this release, the designated person(s) above will be able to speak to any member of the medical staff. Furthermore, I understand that these medical practices cannot be held liable for any information the above stated person(s) may obtain regarding my medical and billing information.

_____ _____

Signature of Patient or Patient Representative *Date*

_____ _____

Signature of Witness *Date*