GASTROENTEROLOGY CONSULTANTS, P.A.

REFERRING DOCTOR INFORMATION

PATIENT NAME:_____ACCOUNT#:_____

WERE YOU **REFERRED** TO THIS OFFICE BY A DOCTOR? IF SO, PLEASE PROVIDE THE FOLLOWING INFORMATION:

REFERRING DOCTOR'S NAME: _____TELEPHONE:_____

ADDRESS: _____

PLEASE NOTE: ALL HMO POLICY HOLDERS MUST FILL IN A REFERRING DOCTOR'S INFORMATION.

WOULD YOU LIKE US TO SEND INFORMATION REGARDING YOUR VISITS TO ANOTHER PHYSICIAN (OTHER THAN THE ABOVE NAMED DOCTOR)?

PHYSICIAN'S NAME:_____TELEPHONE:_____

ADDRESS: _____

I DO NOT WISH TO HAVE ANY OF MY MEDICAL INFORMATION SENT TO ANY DOCTOR. INITIAL_____

DESIGNATED REPRESENTATIVE

PLEASE DESIGNATE **ONE** REPRESENTATIVE TO OBTAIN MEDICAL INFORMATION FOR YOU SHOULD YOU BECOME UNABLE TO CONTACT THIS OFFICE. THE LAW **ONLY** PERMITS MEDICAL INFORMATION TO BE GIVEN TO THE PERSON YOU DESIGNATE. PLEASE NOTIFY ALL OTHER RELATIVES AND FRIENDS THAT NO MEDICAL INFORMATION WILL BE GIVEN TO ANY OTHER PERSON.

I DESIGNATE:_____INITIAL_____

ADVANCE DIRECTIVE

ADVANCE DIRECTIVES ARE LEGAL DOCUMENTS THAT ALLOW YOU TO MAKE INFORMED DECISIONS ABOUT END-OF-LIFE CARE . THE DIRECTIVE GIVES YOU THE OPTION TO LET YOUR FAMILY, FRIENDS, AND HEALTH CARE PROFESSIONALS BE AWARE OF YOUR PERSONAL DECISIONS REGARDING YOUR END-OF-LIFE CARE.

DO YOU HAVE AN ADVANCE DIRECTIVE? YES/NO: INITIAL_____

IF NO, WOULD LIKE MORE INFORMATION ON AN ADVANCE DIRECTIVE? YES/NO:

CONSENT FOR USE AND DISCLOSURE OF INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I acknowledge receipt of GASTROENTEROLOGY CONSULTANTS, P.A. **Notice of Privacy Practices** and I consent to Gastroenterology Consultants P.A. use and disclosure of my health information and insurance/payment information which specifically identifies me or which can reasonably be used to identify me for treatment, payment and health care operations in accordance with Gastroenterology Consultants P.A. **Notice of Privacy Practices**. I understand that while this consent is voluntary, if I refuse to sign this consent, Gastroenterology Consultants, P.A. can refuse to treat me.

I understand that I have the right to request that Gastroenterology Consultants, P.A. restrict how my health and insurance/payment information is used or disclosed to carry out treatment, payment or healthcare operations. I understand that Gastroenterology Consultants, P.A. does not have to agree to such restrictions but that once such restrictions are agreed to, Gastroenterology Consultants, P.A. must adhere to such restrictions.

I understand that I may revoke this consent at any time by notifying Gastroenterology Consultants, P.A. in writing, but if I revoke my consent, such revocation will not affect any actions that Gastroenterology Consultants, P.A. took before receiving my revocation.

PATIENT/REPRESENTATIVE SIGNATURE:_____**DATE:**_____