DIGESTIVE CARE

ARKANSAS SURGERY & ENDOSCOPY CENTER **NEW PATIENT REGISTRATION**

PATIENT INFORMATION

Name: (Last, First, Middle Initial): ________________________________ **Maiden:** ____________________
Address: ____________________ **City:** ____________ **State:** ____________ **Zip:** ____________
DOB: ____________ **SSN:** ________________ **Ph:** ________________ **Cell:** ________________
Occupation: ________________________ **Employer:** ________________________________
Marital Status: **M S D W** **RACE: B W O**
Emergency Contact: ________________ **Relationship:** ________________ **Ph:** ________________

If the Patient is a minor (under the age of 18), please provide information for the parent or legal guardian.

Patient/Legal Guardian Name: ________________________________ **Ph:** ________________

INSURANCE INFORMATION

Primary Insurance: ________________________________ **ID:** ________________________
Plan: ________________________________ **Group:** ________________________________
Policy Holder's Name: ________________________________ **DOB:** ____________________

Secondary Insurance: ________________________________ **ID:** ________________________
Plan: ________________________________ **Group:** ________________________________
Policy Holder's Name: ________________________________ **DOB:** ____________________

Primary Care Physician: ____________________ **City:** ________________ **Ph:** ________________
Pharmacy: ____________________________ **City:** ________________ **Ph:** ________________

AUTHORIZATION

I certify that the above information is true and accurate I authorize the release of any medical or other information necessary to process a claim or continue medical treatment. I also authorize payment of medical benefits paid directly to Digestive Care / Arkansas Surgery & Endoscopy Center. I acknowledge that I am responsible for payment if my insurance company denies my claim.

________________________________ ____________________
Patient Signature **Date**

________________________________ ____________________
Patient or Legal Guardian Signature (If Patient Is a Minor) **Date**

Patient Account Payment & Collections Policy

At **Digestive Care / Arkansas Surgery & Endoscopy Center**, we value you as a patient. In order to continue to provide exceptional service to all our patients/customers, timely payment of your account is crucial. You have the power to avoid the following penalty by discharging your debt with our office when it is due.

If you fail to pay your account in full or if satisfactory payment arrangements are not timely made and timely payments are not made pursuant to the payment arrangement within 30 days following your default, we will refer your account to a collection agency.

In the event a collection agency is hired to collect any outstanding amount, you agree to pay a collection fee in the amount of thirty percent (30%) of the outstanding balance. You will be responsible for paying the collection fee that the collection agency charges for the collection of your debt and that collection fee of thirty percent (30%) will be added to your debt and collected by the collection agency. By signing below, you understand and agree to pay that collection fee.

Also, please understand that by signing this agreement in the space provided for you below, you also agree to be solely responsible to pay the other collection fees incurred by **Digestive Care / Arkansas Surgery & Endoscopy Center** and/or its assignee that are collection fees for court costs – such as filing fees, recording fees, service of process fees and attorney's fees, which may be awarded by the Court, all of which are associated with the collection of your debt.

"Should my account become overdue and subsequently transferred to a collection agency, I specifically agree to pay a collection fee of thirty (30%) to Digestive Care / Arkansas Surgery & Endoscopy Center and/or its assignee and the other collection fees outlined above in recovery associated with the collection of this debt in addition to the outstanding debt."

____

Patient Name

____ ____________________

Patient Signature **Date**

____ ____________________

Digestive Care / Arkansas Surgery & Endoscopy Center **Date**

DIGESTIVE CARE
ARKANSAS SURGERY & ENDOSCOPY CENTER

FINANCIAL POLICY

Dear Patient,

Thank you for choosing us as your healthcare provider. Our main concern is that you receive the proper and optimal treatment to restore your health. Therefore, if you have any questions or concerns about our payment policies, please do not hesitate to ask our account representative.

We ask that all patients read and sign our policy as a token of their acceptance as well as our patient information form prior to seeing the doctor.

PATIENT RESPONSIBILITY, DEDUCTIBLES, CO-PAYMENTS & CO-INSURANCE ARE DUE AT THE TIME SERVICES ARE RENDERED.

The percentage amount given the day of service is an estimate based on information received from your Insurance. Any difference once your Insurance pays will be billed to you.

We accept cash, checks and for your convenience, Master Card and Visa. We will be happy to help you process your insurance claims for reimbursement.

We can accept assignment of ***MOST*** insurance benefits. However, you must understand and agree that: 1) your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our relationship is with you, not your insurance company. 2) All charges are your responsibility whether the insurance company pays or not. Not all services are covered benefits in all contracts. 3) We will file the claim with the insurance company on your behalf. ***HOWEVER, YOUR DEDUCTIBLE, CO¬ PAYMENTS and PERCENTAGE ARE DUE BY YOU AT THE TIME OF SERVICE.***

______________________________	______________________	___________
PATIENT NAME	**PATIENT SIGNATURE**	**DATE**

BILLING EXPLANATION

PLEASE READ THIS PAGE CAREFULLY

Please be informed that once your procedure has been done, the patient or the patient's insurance will receive three (3) to four (4) bills.

1) **DIGESTIVE CARE, P.A**
   - The bill received from DIGESTIVE CARE, P.A. will be the PHYSICIAN'S FEE only. This is what the doctor charges for performing the procedure.
2) **ARKANSAS SURGERY & ENDOSCOPY CENTER "ASEC"**
   - The bill received from ASEC is the FACILITY CHARGE only. This is charged by the surgery center for the facility provided to the physician to perform the procedure
3) **ASC ANESTHESIA. PLLC**
   - The bill received from ASC ANESTHESIA will be for the ANESTHESIA SERVICES only provided at the time of the procedure
4) **PATERSON DIAGNOSTICS. INC**
   - The bill received from PATERSON DIAGNOSTICS will be for any pathology (biopsies) if required during the procedure.

If you have any questions or concerns, please do not hesitate to ask our account representative

______________________________	______________________	___________
PATIENT NAME	**PATIENT SIGNATURE**	**DATE**

DIGESTIVE CARE

ARKANSAS SURGERY & ENDOSCOPY CENTER

I have received and or/ reviewed the notice of **PRIVACY PRACTICES.**

PLEASE PRINT

NAME: ______________________________ **DOB:** ____________________

SIGNATURE: ______________________________ **DATE:** ____________________

I request future update to be provided to me **YES** **NO**

I **refuse** to sign this acknowledgement of **PRIVACY PRACTICE**

PLEASE PRINT

NAME: ______________________________ **DOB:** ____________________

SIGNATURE: ______________________________ **DATE:** ____________________

I have attempted to obtain patient signature and explained the **NOTICE OF PRIVACY PRACTICES.**

HIPPA OFFICER: ______________________________ **DATE:** ____________________

AUTHORIZATION TO SHARE PROTECTED HEALTH INFORMATION

While you are a patient here at DIGESTIVE CARE and/or ARKANSAS SURGERY & ENDOSCOPY CENTER, we want to protect your health information However, you may have family or friends that you want us to share information about your illness. Please understand, we are unable to share information with anyone that has not been listed below.

The following individuals **may be told** about illness/ treatment:

Name: ____________________ Relationship: ______________ Ph: ______________

Name: ____________________ Relationship: ______________ Ph: ______________

Name: ____________________ Relationship: ______________ Ph: ______________

Name: ____________________ Relationship: ______________ Ph: ______________

Do not share my health information with the following individuals:

Name: ____________________ Relationship: ______________ Ph: ______________

Name: ____________________ Relationship: ______________ Ph: ______________

____________________ ____________________ ______________

PATIENT NAME **PATIENT SIGNATURE** **DATE**

DIGESTIVE CARE
ARKANSAS SURGERY & ENDOSCOPY CENTER

<u>NO-SHOW/ CANCELLATION POLICY</u>

DIGESTIVE CARE and **ARKANSAS SURGERY & ENDOSCOPY CENTER** are committed to the delivery of quality care in a professional, caring, and compassionate manner. In order to provide efficient care for all of our patients, we have established the following process:

A **"*NO SHOW APPOINTMENT*"** is defined as any confirmed office appointment which is missed without being **cancelled 48-Hours in advance.**

Our office will charge the patient **$150.00** for a **no show confirmed office appointment**. Office appointments are defined as new or follow-up in person or telehealth appointments at Digestive Care.

A **"*NO SHOW FOR PROCEDURES*"** is defined as any scheduled confirmed procedure which is missed without being **cancelled 48-Hours in advance**. Our office will charge the patient **$300.00** for a **no show confirmed procedure**. Scheduled confirmed procedures are defined as any confirmed procedure scheduled at Arkansas Surgery & Endoscopy Center.

At the discretion of our Physicians, patients may be dismissed from our clinic if he/she fails to show for any scheduled appointments(s).

______________________	______________________	____________
PATIENT NAME	**PATIENT SIGNATURE**	**DATE**

NOTICE TO CLINIC PATIENTS

If you are scheduled for a clinic visit at **DIGESTIVE CARE,** you **MUST** speak with a member of our office **2 Business Days** prior to your visit. Our representative will contact you and ask a series of questions pertaining to your recent health. This is necessary to provide quality patient care; this will allow our office to gather any necessary medical records prior to your arrival. Please contact our office and speak with a representative if you have not been contacted. You will not be seen on the day of appointment if we do not speak with you 2 business days prior to clinic visit, this will be considered a cancellation/no show and you will need to be rescheduled.

NOTICE TO PROCEDURE PATIENTS

If you are scheduled for a procedure at **ARKANSAS SURGERY & ENDOSCOPY CENTER**, you **MUST** speak with a member of our office **2 Business Days** prior to your procedure. Please contact our office and speak with a representative if you have not been contacted. If we do not speak with you 2 business days prior to procedure, you will be considered a cancellation/no show. This is not only to assist with any prep questions, but gather any changes in medical history as well as maintain a procedure schedule that benefits both the facility and patient's valuable time. Schedule times previously given on your day of visit may change due to cancellation(s) or unforeseen circumstances. The procedure time given is your check-in time. Your actual procedure time will depend on multiple factors that day. Every effort will be made to minimize your wait time.

______________________	______________________	____________
PATIENT NAME	**PATIENT SIGNATURE**	**DATE**

MEDICAL RECORDS RELEASE AUTHORIZATION

TO: ____

I, ____**, do hereby authorize and request you to release**

all my medical records to:

DIGESTIVE CARE PA
ARKANSAS SURGERY & ENDSOCOPY CENTER

4800 South Hazel Street	**14918 Cantrell Road**	**1600 West C Place**
Pine Bluff, AR 71603	**Little Rock, AR 72223**	**Russellville, AR 72801**
Ph: (870) 534-5533	**Ph: (501) 663-4747**	**Ph: (501) 663-2727**
Fax: (870) 534-5535	**Fax: (501) 663-4757**	**Fax: (501) 663-2747**

Please Print:

Name: ____ **DOB:** ______/______/________
(LAST) (FIRST) (MI) (MO) (DAY) (YEAR)

Address: ____
(STREET) (CITY) (STATE) (ZIP)

SIGNATURE: ____ **DATE:** ____________________

WITNESS: ____ **DATE:** ____________________

CONFIDENTIALITY NOTICE

THE INFORMATION CONTAINED IN THIS FASCIMILE MESSAGE MAY BE PRIVILEGED AND CONFIDENTIAL INFORMATION. IT IS INTENDED ONLY FOR THE USE OF THE INDIVIDUAL OR ENTITY TO WHICH IT IS ADDRESSED. IF THE READER OF THIS MESSAGE IS NOT THE INTENDED RECIPIENT OR THE EMPLOYEE OF AGENT RESPONSIBLE FOR DELIVERING THE MESSAGE TO THE INTENDED RECIPIENT, YOU ARE HEREBY NOTIFIED THAT ANY USE. DESSEMINATION, DISCLOSURE, OR COPYING OF THIS FASCIMLE IS STRICTLY PROHIBITED. IF YOU HAVE RECEIVED THIS FACSIMILE IN ERROR, PLEASE IMMEDIATELY NOTIFY US BY TELEPHONE AT THE NUMBER LISTED ABOVE AND RETURN THE ORIGINAL MESSAGE TO THE ADDRESS VIA MAIL.

MEDICATION LIST

NAME: ____ **DOB:** _______/______/____________

(LAST) **(FIRST)** **(MI)** **(MO)** **(DAY)** **(YEAR)**

PHARMACY: ____ **PH:** ________________________

(NAME) **(STREET)** **(CITY)**

MEDICATION	DOSAGE	FREQUENCY	PRESCRIBER

If you brought a list with you, please give to front desk to make copy and do not complete this form.