Gastroenterology Center of the South
8120 Main St. Houma, LA 70360
(985) 851-5206

**<u>If you have insurance, your name must be written as it is shown on your insurance card.</u>** Your account will be under this name. No exceptions are made for change in marital status, nicknames or any other reason. Your driver's license should also match the name on your insurance card. If it does not match, you should update the incorrect information and notify us as soon as possible.

PATIENT NAME: ______________________________________________________

MAILING ADDRESS: _________________________________________________________

CITY: ___________________________ STATE & ZIP CODE: _________________________

DATE OF BIRTH: ____/_____/______ SOCIAL SECURITY # __________________________

PHONE # (______)________-______________ CELL# (______)_______-_______________

PATIENT'S EMPLOYER: __________________________________________________

SPOUSE'S NAME (PARENT IF UNDER 18): _____________________________________

SPOUSE'S EMPLOYER: ___________________________________________________

INSURANCE INFORMATION

**<u>PRIMARY</u>**: NAME OF INSURACE COMPANY _____________________________________

SUBSCRIBER'S NAME ____________________________________________________

SUBSCRIBER DATE OF BIRTH ______/________/________SSN#_____________________

SUBSCRIBER RELATIONSHIP TO THE PATIENT __________________________________

SUBSCRIBER'S EMPLOYER ________________________________________________

**<u>SECONDARY:</u>** NAME OF INSURANCE COMPANY _______________________________

SUBSCRIBER'S NAME ____________________________________________________

SUBSCIRBER'S DATE OF BIRTH ____/____/____ & SSN # ___________________________

SUBSCRIBER'S RELATIONSHIP TO THE PATIENT _______________________________

SUBSCRIBER'S EMPLOYER ________________________________________________

I HAVE READ, UNDERSTAND AND AGREE TO THE OFFICE APPOINTMENT AND FINANCIAL POLICY SET FORTH BY GASTROENTEROLOGY CENTER OF THE SOUTH. I, THE UNDERSIGNED CERTIFY THAT I (OR MY DEPENDENT) HAVE THE ABOVE INSURANCE AND ASSIGN DIRECTLY TO GASTROENTEROLOGY CENTER OF THE SOUTH ALL INSURANCE BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I HEREBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO MY INSURANCE COMPANY AND OR PHYSICIANS. I HAVE BEEN INFORMED OF THE GASTROENTEROLOGY CENTER OF THE SOUTH'S NOTICE OF PRIVACY PRACTICES. A COPY OF THE NOTICE IS ALSO AVAILABLE UPON REQUEST. IF I CHOOSE, OR AM NOT ABLE TO SIGN. A STAFF MEMBER WILL SIGN HIS/HER NAME AND DATE. THIS ACKNOWLEDGEMENT WILL BE FILED WITH MY RECORDS.

**SIGNATURE: ________________________________________ DATE ____/____/____**

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**PATIENT NAME**: ______________________________________________________________

DATE OF BIRTH: ____/____/____

MARITAL STATUS (CIRCLE ONE): SINGLE MARRIED WIDOWED DIVORCED

GENDER (CIRCLE ONE): MALE FEMALE

RACE (CIRCLE ONE): AMERICAN INDIAN AMERICAN INDIAN/ALASKA NATIVE

ASIAN BLACK/AFRICAN AMERICAN

WHITE/CAUCASIAN OTHER

ETHNICITY (CIRCLE ONE): NOT HISPANIC OR LATINO HISPANIC OR LATINO

PRIMARY LANGUAGE: ______ENGLISH _____OTHER:___________________________

The above information is being requested for meaningful use electronic requirements as set forth by the Medicare Electric Healthcare Record Incentive Program and in compliance with the Health Information Technology for Economic and Clinical Health Act (HITECH). Where there are laws or regulations covering this type of information, we will collect, retain and use the data in full compliance with applicable laws. We do not provide the information we collect to other third parities unless it is required to do so by a valid court order, government agency order or information request, or unless it has legitimate business for doing so and the third party agrees to similar restrictions or disclosure and use of information.

## CONSENT FOR RELEASE OF HEALTH INFORMATION

This clinic is committed to protecting your health information as stated in our notice of privacy policy. However if you request us to discuss anything concerning your health information with anyone than yourself, we must have written consent. This information may include, but not limited to, test results appointment, medications and diagnosis. Please check the appropriate box and add information if indicated.

____ I DO **NOT** WANT MY HEALTH INFORMATION DISCUSSED WITH ANYONE.

____ I AUTHORIZE THE GASTOENTEROLOGY CENTER OF THE SOUTH TO DISCUSS MY HEALTH INFORMATION WITH THE FOLLOWING FAMILY MEMBER(S) AND/OR INDIVIDUAL(S).

| NAME | RELATIONSHIP | PHONE# |
|---|---|---|
| ________________________________ | ________________________________ | (____)______-______ |
| ________________________________ | ________________________________ | (____)______-______ |

AUTHORIZED INDIVIDUAL(S) WILL REMAIN IN EFFECT AS OF THIS DATE UNTIL I MAKE CHANGES.

**PATIENT'S SIGNATURE _____________________________________________**_______________**DATE**____________

GASTROENTEROLOGY CENTER OF THE SOUTH

# FINANCIAL POLICY

## OUR PRATICE POLICY:

We are dedicated to providing you with the best possible care and service, and we want to help you understand our financial policies as an essential part of your care and treatment. To assist you, we have the following payment policy. If you have any questions, please fell free to discuss them with our staff. Unless either you or your health insurance carriers have made other arrangements in advance, full payment is due at the time of services. For your convenience we accept Visa, MasterCard, Discover, and American Express.

## PRIVATE PAYERS:

If you do not currently have insurance coverage, full payment is required at the time of service. Any problems with payment for procedures will be addressed to the collections department.

## INSURANCE POLICY:

We have made prior arrangements with many insurers and other health plans. We will bill those plans with which we have an agreement and will collect any required co-payments at the time of service. The co-payment will be collected before you leave our office. If a procedure is scheduled, a deposit on that procedure will be collected. This deposit may not cover the total co-insurance that will be due, so there may be additional charges. Please also note that the day of the procedure which is done at Terrebonne General Medical Center as an Outpatient Procedure, there will also be a charge for Terrebonne General Medical Center.

In the event that your health plan decides that a service is “non-covered”, you will be responsible for the entire charge. In this event we will bill you and payment is due no later than 30 days from receipt of that statement.

If you have insurance coverage with a plan with which we do not have an agreement, we will prepare and send the claim form for you, free of charge. In this case, your insurer will send the payment directly to you. Therefore charges for your care and treatment are due at the time of service.

We will also bill your health plan for all services we provide in the hospital. Any balance due is your responsibility and is due no later than 30 days from receipt of a statement from our office.

## COLLECTION POLICY:

I agree that if payment is not made in a timely manner and should this office find it necessary to place my account with an agency for collection, I agree to pay a collection fee for 50% of the amount owed at the time of placement. In addition, I also agree to pay any and all court costs and attorney fees at the rate of 33.3% or $75.00, whichever is greater, on any balance due and owing.

## MISSING APPOINTMENT:

In order to provide the best possible service and availability to all our patients, it is imperative that you call us for any cancellations at least one day in advance. As a courtesy to others, please contact us as early as possible if you know you will need to reschedule an appointment.

I have read and understand the financial policy of Gastroenterology Center of the South and I agree to abide by its terms. I also understand and agree that such policies may be changed from time to time by the practice.

______________________________________ __________________

**Signature of Patient** **Date**

# *Patient Portal Announcement*

In our ongoing efforts to improve the quality of care that **Gastroenterology Center of the South** provides, we are pleased to announce the availability of our Patient Portal to better serve you. The Patient Portal is a secure, web-based system that allows you to view certain aspects of your medical record. The portal also allows you to securely communicate with us between visits for **NON-URGENT** issues and questions. You can even download and securely transmit a summary of your medical record to other web-based applications and providers of care. Over time we will be phasing in various features and functions that will be available through the Patient Portal.

## What Can I do with the Portal?

In its initial phase, functions available through the portal include:

● **View your Record -** You can view your current medications, medication allergies, and medical problems. The medical problems listed may be limited to only those problems for which we are providing care.
● **Appointments -** You can view summaries of past visits that we may have posted to your portal account and you can also view details (i.e. date, time, type of visit) for upcoming appointments.
● **Lab & Test Results -** Once your doctor reviews your lab or test results, we will post these results, along with a personal note from your doctor about the results to your Patient Portal account.
● **Secure Messaging -** The Patient Portal allows you to securely communicate with our office. The Secure Messaging function allows you to send messages to us and for us to send messages back to you. Secure messages you send to us through the portal, much like phone messages, will be routed by our office staff to the appropriate person and will enable us to respond to you in the most appropriate fashion. In other words, this is not necessarily a message sent directly to your doctor, but potentially may be screened and routed by our nurses and administrative staff. Please keep in mind that messages you send (and our responses) will automatically be filed in your electronic medical record at our office.
● **Generate a Personal Health Record -** This function will enable you to generate a summary of your medical record in a secure and standard format. This summary record can then be downloaded or transmitted to another provider (or system) that is compliant with industry standard formats.

## Is My Information Secure?

At **Gastroenterology Center of the South**, we take your privacy and the security of your personal health information very seriously. Both our Electronic Medical Records system and the Patient Portal have been certified by the proper federal authorities to ensure the security of your information. Additionally, our clinic has employed additional Information Technology safeguards to protect the data. Finally, the process for you to initiate the Patient Portal functions, and for you to receive ongoing information through the portal, has been designed to provide you, and persons you authorize, to have access to your personal health information. However, in today's internet connected world it is all but impossible to completely ensure privacy and security. We are taking all steps we can, but there are steps you should also take to ensure security and privacy, including;

● **Personal Email Address -** We will only activate your Patient Portal account through the use of a personal email address that you provide to us. We will not activate your Patient Portal account until we receive this email address from you. We will not send personal health information to this email account, but rather you will use that email address, along with a unique password that you choose, and the last four digits of your social security number, to authenticate your access to the Patient Portal where your electronic health information will be located.
● **Email Notifications -** Once you have authorized us to activate your Patient to us. This Welcome Email will provide you with the information necessary for you to login to the portal, view your health information, and begin interacting with us. When we "post" information to your Patient Portal, you will receive an email notifying you that new information is available and you will again login to the portal to view the information.

## Do you want to participate in our ONLINE PATIENT PORTAL?

Along with this announcement, we have provided you with complete instructions on how to activate your online access to the portal as well as complete instructions on how to use the portal. Please choose to either authorize us to activate your account or decline the activation using the appropriate section below:
Portal account, we will send a Welcome Email to the email address you provided

## CHOOSE ONLY ONE BOX AND SIGN UNDER THE BOX CHOSEN

☐ **DECLINE**

I have read and understand the Patient Portal Announcement, the Patient Portal Online Access Instructions, and the Patient Portal Guidelines & Usage Instructions and choose to decline the use of The Patient Portal at this time.

**Patient Name:**_____________________________________ **Date of Birth:**_____________________

☐ **ACCEPT**

### Portal ACCEPTANCE

I have read and understand the Patient Portal Announcement, the Patient Portal Online Access Instructions, and the Patient Portal Guidelines & Usage Instructions and authorize **Gastroenterology Center of the South** to activate my Patient Portal Account using the email address indicated below. I understand that it is my responsibility to safeguard the email address and my Patient Portal Password in order to maintain the security and privacy of my personal health information. I also understand that **Gastroenterology Center of the South** will use the Patient Portal as a means of communicating with me when appropriate. I further understand that the Patient Portal is not to be used for urgent medical needs nor does it replace the need for me to keep my regular appointments with my doctor:

**Patient Name:**___________________________________ **Date of Birth:**_____________________

**Email Address to use in conjunction with my account:**_______________________________________________

****PLEASE NOTIFY US IMMEDIATELY IF YOU CHANGE YOUR EMAIL ADDRESS ****