NASHVILLE DIGESTIVE DISEASE CENTER

Patient information

Name:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Sex: Male/ Female Date of birth: _____ SS#:_____

Marital Status: (please circle) Married Single Separated Divorced Widow/Widower

Home phone:_____ Cell Phone:_____

Employer's Name: _____ Work Phone:_____

Email:_____

**Email is MANDATORY so that you may access your medical records from your personal computer.

Pharmacy Name: _____ Phone: _____

Pharmacy Address: _____

Primary Care Doctor:_____ Phone:_____

Reason for Referral:_____

Person to Contact in Case of Emergency: _____

Phone:_____ Relationship:_____

Address:_____

May we leave a message on your answering machine? Yes No

May we leave a message with a family member? Yes No

Insurance Information (Even though we make a copy of your insurance card, we you to fill out your insurance information)

***Primary Insurance** _____

Address _____

(Street Address) (City) (State) (Zip Code)

Policyholder's ID#_____ Group#_____

Policyholder's Name _____ SS#_____ DOB_____

Patient's relationship to policyholder: Self Spouse Child Other_____

***Secondary Insurance** _____

Address _____

(Street Address) (City) (State) (Zip Code)

Policyholder's ID#_____ Group#_____

Policyholder's Name _____ SS#_____ DOB_____

Patient's relationship to policyholder: Self Spouse Child Other_____

Financial Policy

We strongly feel that patients deserve the very best medical care that we can provide. Everyone benefits when financial arrangements are agreed upon. We have prepared this material to acquaint you with our policy . Our professional services are rendered to you, not to the insurance company. Payment for treatment is your responsibility.

Financial Agreements

(Please initial the following, please do not use checkmarks)

_____If my insurance coverage is canceled; I understand that I am responsible for payment of services rendered to myself or dependents at the time service is rendered.

_____I understand if I fail to pay amounts owed: the clinic has the right to secure an outside collection agency and /or attorney to collect the unpaid debt and to report the unpaid debt to the credit-reporting agency. I further understand that I will be responsible for any additional charge or fees necessitated by securing the collection agency or attorney, including reasonable attorney's fees.

Insurance Authorization and Assignment

(Please initial the following please do not use checkmarks)

_____I hereby authorize the release of any information necessary to process insurance claims and

request payment of benefits to be made for services rendered to my dependents or myself.

_____I understand I am responsible *at the time of services* for paying any required co-payment and deductible.

How did you hear about our office: Doctor's office_____ , T.V Commercial_____, Online_____ , Friend_____, Other_____.

MEDICATION LIST

MEDICATION	Dosage	Frequency	Physician

Are you allergic to any medication? Yes No

If (yes)please list below:_____

_____

_____

NOTICES

This is to inform you that *NASHVILLE DIGESTIVE DISEASE CENTER* is a physician owned Gastroenterologist Office and has no affiliation with any private or governmental organization. The facility is usually inspected and operates under the rule set for operation of ambulatory surgical centers in the state and country. It abides by the law and has no tolerance for any form of discrimination. Any questions or concerns should be forwarded to the management.

X_____

Patient Signature / Date

X_____

Guardian /Caregiver Signature / Date

Nashville Digestive Disease Center
1308 Briarville Rd Madison TN 37115

Important Notice for All Patients

Kindly give a 24 hour advance notice if you are unable to keep your scheduled appointment time. Missed appointment Policy is the policy of this clinic to require 24 hours advance notice for all appointments cancellations to allow the physicians maximum availability for their patients. To ensure availability is managed appropriately, it is necessary for us to have the following policy for missed appointments:

First Missed Appointment: A courtesy notification will be sent to the patient of missed appointment and our clinic policy regarding missed appointments.

Second Missed Appointment: A notification will be sent to the patient of missed appointment, along with a copy of our clinic policy, and a bill for a missed appointment charge of $500.00 for a procedure and $50.00 for an office visit. This charge is not covered by insurance and it is the patient's responsibility. The missed appointment fees must be paid prior to future office visits.

Patient Name: _____

Patient Signature: _____

Date: _____