DIGESTIVE DISEASE GROUP, PA
103 LINER DRIVE
GREENWOOD, SC 29646-2311
(864) 227-3636

THE GREENWOOD ENDOSCOPY CENTER, INC
103 LINER DRIVE
GREENWOOD, SC 29646-2311
(864) 227-3838

Patient Information Form

Name: ___________________ ___________________ ______________ Peferred Name ______________________
(Last) (First) (Middle)

Birth Date: _________________ SS#:_______________________ Sex: ☐ Male ☐ Female

Billing Address: ____ City:_______________________

State: _______________ Zip Code _____________ County _______________ Preferred Language: _______________

Race:____________________ Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown ☐ Declines to Specify

Home Phone:___________________________________ Work Phone:______________________________________

Cell Phone:_____________________________________ Email ____

Appointment reminders by: ☐ Phone Call ☐ Text (SMS) ☐ Email

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Other ____________________

Employer & Address ____

Person Responsible for Payment, Relationship, & Address If Not Patient:
____

Emergency Contact: _________________________________ ____________________ ____________________
(Name) (Relationship) (Phone#)

Referring Physician: ______________________________ Primary Physician: ______________________________

Pharmacy Name:________________________________ Pharmacy Phone #: _______________________________

Is the Patient Selfpay? ☐ YES ☐ NO

Primary Insurance Coverage

Name of Insurance ____________________________________ Member ID: _______________________________

Insured Name(Self if patient):___________________________________ Insured's DOB:_____________________

Insured Employment:_____________________________ Relationship to Insured: _________________________

Secondary Insurance Coverage

Name of Insurance ____________________________________ Member ID: _______________________________

Insured Name(Self if patient):___________________________________ Insured's DOB:_____________________

Insured Employment:_____________________________ Relationship to Insured: _________________________

PLEASE COMPLETE BOTH SIDES OF THE FORM

Verifying Employee's Initials & Date _______________ Account # ___________________________

DIGESTIVE DISEASE GROUP, PA AND THE GREENWOOD ENDOSCOPY CENTER INC

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Digestive Disease Group, PA (DDG) and/or The Greenwood Endoscopy Center, Inc (GEC) to use and disclose protected health information about me to carry out treatment, payment, and healthcare operations. The Notice of Privacy Practices provided by DDG and GEC describes such uses and disclosures more completely.
I have the right to review the Notice of Privacy Practices prior to signing consent. DDG and/or GEC reserves the right to change its' Notice of Privacy Practices at any time. A copy of this notice has been provided to me.
With this consent, DDG and/or GEC may mail to my home or other alternative location, may email my specified email address and/or call my home or other specified number, including my cell number, and leave a message in reference to any items that assist the practice or center in carrying out treatment, payment and healthcare operations. This may include automated appointment reminders, insurance items and any calls pertaining to my clinical care including laboratory tests and biopsy results among others. This may also include contact by a Third Party Collection Agency should my account be assigned to collections if delinquent or past due.

Electronic Communication Consent:
I understand that DDG and/or GEC may communicate with me using electronic methods, including text messaging, secure messaging platforms, and/or patient communication applications, to provide appointment reminders, care coordination, and other information related to my treatment, payment, and healthcare operations. These communications may involve third-party service providers contracted by the practice who are required to safeguard my protected health information. I acknowledge that while reasonable safeguards are in place, electronic communications may carry some risk of unauthorized access. By providing my contact information, I consent to receive such communications unless I opt out in writing. I understand that I may request alternative methods of communication or restrict certain types of electronic communications at any time.
I have the right to request that DDG and/or GEC restrict how it uses or discloses my protected health information to carry out treatment, payment, and healthcare operations. The practice and/or center are not required to agree to my requested restrictions, but if it does, it is bound by this agreement. I have the right to a list of the disclosures made by DDG and/or GEC of my protected health information.
By signing this form, I am consenting to allow DDG and/or GEC to use and disclose my protected health information to carry out treatment, payment, and healthcare operations. I hereby assign to DDG and/or GEC all payment for medical services rendered to me or my dependents. I understand that I am responsible for any amount not covered by my insurance. I also understand that a prompt refund will be given for my overpayment.
I may revoke my consent in writing except to the extent that the practice and/or center have already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, DDG and/or GEC may decline to provide treatment to me.

Signed by: ____
Signature of Patient or Legal Guardian

________________________ Date

________________________ Relationship to Patient

____
Print Patient's Name

____
Print Name of Legal Guardian if applicable

Ways in which we may reach you. Remember, we may need to reach you promptly regarding your appointment or issues that may affect your health.

Home Phone:_________________________ Work Phone:_________________________ Mobile Phone:__________________________

Mailing Address:____

E-mail: _____________________________________

May we leave a message on your answering machine? ☐ Yes ☐ No May we leave a message at the phone number(s) listed above? ☐ Yes ☐ No

May we leave normal results (for example normal lab, biopsy, x-ray, etc) on an answering machine? ☐ Yes ☐ No

May we speak with your spouse? ☐ Yes ☐ No Name:_____________________________ Contact number:______________________

Please list other individuals with whom we may discuss your health or medical care, please include their phone numbers:

____

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<u>Advance Directives:</u> You have the right to bring a copy of your Advance Directive, such as a living will or durable power of attorney for health care with you, but we do not formulate these. S.C. law establishes a priority list of relatives who may consent to treatment if you are unable to do so yourself. You have the right, by formulating a durable power of attorney for health care, to both supplant that priority list and to give your agent or surrogate, broader authority to act in your behalf with respect to health care matters. You may be asked about advance directives during pre-admission or at admission for your procedure, however The Greenwood Endoscopy Center does not honor advance directives in the event of deterioration or medical emergency.

Advance Directives: ☐ YES ☐ NO _________________ Patient Initials

If yes, are you providing us with a copy? ☐ YES ☐ NO _________________ Patient Initials