Southeast Valley Gastroenterology Consultants, P.C. (SEVG)
Demographic Information Form

Name: _____ **Date of Birth:** MM / DD / YYYY
Last First Mi.

Gender: Male ☐ **Female** ☐ **Age:** _____

Street Address: _____

Social Security # XXX - XX - XXXX

City-_____**State-**_____**ZIP**_____

Email:_____

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

Race: ☐**White** ☐**Black** ☐**Asian** ☐**Native American/Alaska Native** ☐**Native Hawaiian/Pacific Islander** ☐**Decline** ☐**Unknown**

Ethnicity: ☐**Hispanic/Latino** ☐**Not Hispanic/Latino** ☐**Decline** ☐**Unknown**

Home Phone: XXX - XXX - XXXX **Work Phone:** XXX - XXX - XXXX **Mobile Phone:** XXX - XXX - XXXX

Employer Name: _____ **Occupation:** _____

Primary Care or Referring Doctor: _____ **Doctor's Phone:** XXX - XXX - XXXX

Primary Insurance Information:

Insurance Company Name: _____

Policy Holder: _____ **ID#:** _____ **D.O.B:** MM / DD / YYYY

Secondary Insurance Information:

Insurance Company Name: _____

Policy Holder: _____ **ID#:** _____ **D.O.B:** MM / DD / YYYY

FINANCIAL RESPONSIBILITY/ASSIGNMENT: I agree to pay Southeast Valley Gastroenterology Consultants, P.C. (SEVG), for all services rendered. I understand that bills are payable in full upon the rendering of treatment. I understand that SEVG will make good faith efforts to acquire all needed referrals, authorizations needed to cover services provided and will bill my designated insurance coverage identified above as a courtesy. I assign SEVG all benefits due me for services rendered and expenses incurred under any applicable policy of insurance. I understand that I am financially responsible to SEVG for all charges not covered by this assignment and promise to pay any remaining patient balance due. I understand that any co-pays, deductible or co-insurance will be my responsibility and SEVG will require payment for these amounts prior to visits or services being performed.

COLLECTION POLICY: I understand that a patient balance is considered delinquent if payment in full has not be received within 60 days of the final insurance payment. Delinquent balances may be turned over to a collection agency. Balances sent to a Collection Agency will be assessed a penalty of 30% of the remaining balance. I agree that in the event any patient balance of mine is assessed a collection agency penalty I will pay the 30% Collection Agency Penalty in addition to any patient balance owed to SEVG.

AHCCCS/MEDICAID COVERAGE: I understand that SEVG is not a covered provider under the Arizona Health Care Cost Containment System (AHCCCS) and that they do not accept patients with AHCCCS coverage. I represent by signing this form that I am not covered under an AHCCCS insurance plan. Primarily or secondarily.

INSUFFICIENT FUNDS POLICY: If a personal check is returned to SEVG due to insufficient funds an insufficient funds charge of $50.00 will be applied to your account.

As the patient or authorized representative of the patient I certify that I have read this document and that I agree to the terms of outlined within it.

_____ MM / DD / YYYY

***Patient/Authorized Signature** **Date**

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HIPAA CONSENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare Providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physicians' certifications.

I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices and that I may contact this organization at any time to obtain a current copy of this Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I consent to have the following individual(s) involved or notified about my care or treatment:

Name: _____ Phone: XXX - XXX - XXXX___ Relationship to Patient: _____

Name: _____ Phone: XXX - XXX - XXXX___ Relationship to Patient: _____

I consent to be contacted via; Voicemail ☐ Phone Call ☐ Text ☐ Email ☐ for purposes of treatment and/or billing.

I understand that I may revoke this consent in writing at any time, except to the extent that we have acted relying on this consent.

***Patient/Authorized Signature: _____ Date: MM / DD / YYYY**

I wish to have the following individual(s) contacted in case of medical emergency:

Name: _____ Phone: XXX - XXX - XXXX___ Relationship to Patient: _____

Name: _____ Phone: XXX - XXX - XXXX___ Relationship to Patient: _____

☐ **STAT** (If indicated)

875 S. DOBSON RD. CHANDLER, AZ 85224 (480) 899-9800 FAX (480) 899-2994
2730 S. VAL VISTA DRIVE STE. 158 BLDG. 10 GILBERT, AZ 85296 (480) 782-5005

CHARLES M. SCHRON, MD G. ALAN BRACHER, MD MANISH G. AMIN, MD SANDEEP C. PATEL, MD YATIN R. PATEL, MD ANITA E. SPIESS, MD
CHRISTINA SLOAN, PA-C MOLLY WYANT, PA-C JESSICA LAURINO, PA-C JENNIFER SPOHN, PA-C
KELLY M. KOLLMAN, PA-C JENNIFER A. MCPHAIL, PA-C BETHANY A. TENNYSON, PA-C SANDRA L. EHRLER, PA-C MIA RYCKMAN, PA-C

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _____, allow Southeast Valley Gastroenterology Consultants, P.C. (SEVG) to release or receive any necessary medical records, including pathology material.

_____ Date:_____/_____/_____
Patient's Signature

Date of Birth:(MM/DD/YYY) _____/_____/_____ SEVG Physician: _____

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FOR OFFICE USE ONLY:

I authorize Southeast Valley Gastroenterology Consultants P.C. to

☐ **Obtain** information from and/or ☐ **Release** information to:

_____
Name of Provider or Facility

_____
Address

Phone:_____**Fax:**_____

FOR CONTINUITY OF CARE

PLEASE LIMIT RECORDS TO THOSE SPECIFICALLY LISTED BELOW:

Date	Initial Request	2nd Request	3rd Request
Requested for: **CS** **AB** **MA** **SP** **YP** **AS**			