ElmsDigestive.com

ELMS DIGESTIVE

(843) 797-6800

MEDICARE LIFETIME SIGNATURE ON FILE (FOR MEDICARE PATIENTS)

I request that payment of authorized Medicare benefits be made on my behalf directly to this practice for any services furnished to me by the physician. I authorize the release of any medical or other information necessary for processing claims to the practice for Medicare and Medicaid services. _____**Initials**

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign benefits to be paid on my behalf to Elms Digestive Disease Specialists and/or Elms Endoscopy Center, my admitting physician, or other physicians who render service to me. The undersigned individual guarantees prompt payment of all charges incurred for services rendered or balances due after insurance payments in accordance with the policy for payment for such bills of Elms Digestive Disease Specialists and/or Elms Endoscopy Center, my admitting physician, or other physicians who render service to charges not paid for within a reasonable period of time by insurance or third party payer. I certify that the information given with regard to insurance coverage is correct. _____**Initials**

RELEASE OF MEDICAL RECORDS

I authorize Elms Digestive Disease Specialists and Elms Endoscopy Center, my physician, or other physicians who render service to release all or part of my medical records where required by or permitted by law or government regulations, when required for submission of any insurance claim for payment of services or to any physician(s) responsible for continuing care.

_____**Initials**

HIPAA NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received, read and understand your Notice of Privacy Practices. I understand that this information will be used to carry out treatment, payment, and normal healthcare operations of the practice. 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.

_____**Initials**

PATIENT RIGHTS/ADVANCED DIRECTIVES INFORMATION

I have received information verbally and in writing regarding my Patient Rights prior to the date of service. I have also received information regarding Elms Digestive Disease Specialists and/or Elms Endoscopy Center policies pertaining to ADVANCED DIRECTIVES prior to the date of service.

_____**Initials**

AUTHORIZED METHODS OF COMMUNICATION

I hereby authorize Elms Digestive Disease Specialists and/or Elms Endoscopy Center or the physician rendering services to me to communicate information regarding my healthcare treatment and/or billing with:

☐ Spouse: _____ _____Initials

☐ Family Member: _____ _____Initials

☐ Friend: _____ _____Initials

It is okay to leave a call back phone number only with:
_____ Home _____ Cell _____ Work _____Initials

It is okay to leave a detailed message on the answering machine/voicemail on:
_____ Home _____ Cell _____ Work _____Initials

I understand that the authorization for release of information will be valid for one year from the date of signature and can only be revoked upon written notice. By signing below, I acknowledge that this form has been read in full and explained as necessary.

_____ _____

Patient name or name of responsible party **Patient or responsible party signature**

_____ _____

Patient SS# **Patient DOB**

_____

Date