WV GASTROENTEROLOGY & ENDOSCOPY
HIPPA POLICY

Patient Name: ____ Account #: ___________

Date of Birth: _____________________ SSN: ____________________________

I give permission to be contacted in the following manner (please check all that apply):

□ Home telephone: __________________________ □ Work telephone: ________________________

□ Written communication to home/work office □ Ok to leave a message with information home/work

□ Leave message with call-back number ONLY-home □ Leave message with call-back number ONLY-work

□ Ok to leave a message at home with the following family members: __________________________________

Person (s) allowed to receive your medical information:

_______________________________ Relationship: ____________________ Phone: _______________________

_______________________________ Relationship: ____________________ Phone: _______________________

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I CONSENT TO CARE AND TREATMENT
I consent to examination, treatment, and testing by my attending physician, facility personnel or authorized agents who may be involved in my care.

I CONSENT TO USE/DISCLOSURE OF MY MEDICAL INFORMATION
I authorize the use and disclosure of my medical information, including information relating to AIDS and the results of HIV-testing; drug or substance abuse; and mental health related treatment and services for the purpose of treatment, payment and/or healthcare operations.

I HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES
I have received my provider's Notice of Privacy Practices, which tells how my health information may be used and shared. I understand that my provider reserves the right to revise the notice at any time, and that I can always get the current copy by asking for it.

INSURANCE PAYMENTS DIRECTLY TO THE FACILITY
I authorize my provider or any facility providing services to me to directly bill and collect payment from my insurance company, Medicare, Medicaid, or other company that pays my medical bills. I understand that I may receive a separate bill for radiology or laboratory services provided by another facility. I certify that all information given by me in applying for payment by any third party is true and accurate.

I AGREE TO PAY FOR THE COST OF CARE AND TREATMENT AT TIME OF SERVICE
I accept responsibility for the cost of all services provided to me. I understand that I may have to pay charges that are not paid by my insurance company or anyone else. I will pay the collection costs, including court costs; if legal action must be taken to collect my unpaid bill.

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RESPONSIBLE PARTY SIGNATURE **DATE**