GASTROENTEROLOGY CONSULTANTS, P.C.

M. Thomas Riddick, M.D. Melvin Bullock, M.D.

11685 Alpharetta Hwy., Ste 320
Roswell, GA 30076
(770) 442-5882 Fax (770) 754-9749

Patient Name _____Date of Birth _____Male/Female

Social Security Number_____ Email : _____

Address _____Apt. No. _____

City _____State _____Zip _____ Marital Status: _____ Race_____

Home ( )_____Cell ( ) _____ Work ( ) _____

Employer_____Address_____

Employment Status: Full-time Part-time Unemployed Retired Self-Employed Military
(Circle One)

Spouse's Name_____
Spouse's Employer_____Phone_____

Insurance Information: Insured Name_____
(if different than patient) Insured Date of Birth_____
Insured SS#_____
Person to contact in case of Emergency_____Phone_____
Who is your Primary Care Physician?_____Phone_____
Name of Physician Referring you to our practice_____

Insurance Information: I acknowledge that M. Thomas Riddick, M.D. or Melvin Bullock, M.D. may or may not be a part of my provider network for my insurance company and that it is my responsibility to verify that my doctor is on my plan. All professional services rendered are charged to the patient. We will file your insurance as a courtesy; however, the patient is responsible for all fees regardless of insurance coverage.

I hereby authorize Gastro Consultants to furnish all information to insurance carriers concerning my illness and treatments and I hereby assign to the physician all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by my insurance.

Date_____Signature_____

IMPORTANT NOTICE

IT IS POSSIBLE THAT YOUR TREATMENT WILL INCLUDE AN OUTPATIENT PROCEDURE. PLEASE BE AWARE THAT THERE MAY BE CHARGES SEPARATE FROM DR. RIDDICK'S/ DR. BULLOCK'S FEE. I.E., HOSPITAL, ANESTHESIA, PATHOLOGY.

IF YOU HAVE A PROCEDURE THAT IS SCHEDULED AT GEORGIA ENDOSCOPY CENTER THAT NEEDS TO BE CANCELLED, A 4-DAY NOTICE IS REQUIRED. IF THE APPROPRIATE NOTICE IS NOT RECEIVED, A FEE OF $100.00 WILL BE CHARGED TO THE PATIENT. INSURANCE COMPANIES WILL NOT COVER THIS FEE. WE ALSO REQUIRE A 24 HR NOTICE FOR OFFICE VISIT CANCELLATION. A $25 FEE WILL BE CHARGED. (EXCEPTION: ILLNESS OR DEATH IN THE FAMILY)

THERE MAY ALSO BE TIMES WHEN OUR DOCTOR NEEDS TO ORDER TESTING OUTSIDE OF OUR OFFICE, WHICH MAY INCLUDE BLOOD WORK, X-RAYS, ETC. THESE CHARGES ARE NOT PART OF THE OFFICE VISIT AND YOUR REGULAR BENEFITS WILL APPLY.

IF YOU ARE HERE FOR A CONSULTATION VISIT PRIOR TO SCHEDULING A COLONOSCOPY, PLEASE BE ADVISED THAT THIS IS CONSIDERED A SPECIALIST OFFICE VISIT AND NOT CONSIDERED PREVENTATIVE. YOUR USUAL BENEFITS WILL APPLY AS WITH ANY OTHER SPECIALIST OFFICE VISIT.

IF YOUR INSURANCE REQUIRES A REFERRAL TO OUR OFFICE, IT IS THE PATIENT'S RESPONSIBILITY TO OBTAIN. IF A PROCEDURE YOU HAVE SCHEDULED NEEDS TO HAVE PRECERTIFICATION, OUR OFFICE WILL OBTAIN THIS FROM YOUR INSURANCE COMPANY.

IT IS THE PATIENT'S RESPONSIBILITY TO KNOW WHAT HIS/HER INSURANCE BENEFITS ARE AND WHAT THEY WILL OR WILL NOT COVER.

I HAVE READ AND UNDERSTAND THE ABOVE NOTICE.

PATIENT'S SIGNATURE **Date**

PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal information is protected for privacy. The "Privacy Rule" was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical information and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or discloser of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your (PHI). You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

I authorize Dr. Riddick/Dr. Bullock or their staff to leave a message or voicemail on the following phone numbers:

Home_____Work_____Cell_____

_____ _____ _____

Print Name **Signature** **Date**

PATIENT MEDICAL QUESTIONAIRE

Have you ever had a Colonoscopy? _____YES _____NO
If so, when?_____

(Females)
Have you ever had a Mammogram? _____YES _____NO
If so, when ?_____

Have you ever had a Bone Density Study? _____YES ____ NO
If so, when? _____

Have you ever had a Pneumovax Vaccine(for Pneumonia)? ____YES ____NO
If so, when? _____

Please list all current medications:

_____
_____
_____
_____
_____
_____
_____

Allergies:_____
_____

Please provide a pharmacy that you may use:

Pharmacy_____
Address_____City_____
Phone number_____

My preferred method of contact from our office is:

____Phone ____E-mail ____Postal Mail

Signed_____Date_____

Original

Gastroenterology Consultants, P.C.

Acknowledgement of Receipt of Privacy Practices

I, _____ have received a copy of Gastroenterology Consultants, P.C. Notice of Privacy Practices.

_____
Date

_____
Print Name

_____
Signature

OFFICE USE ONLY

On _____ 20___ at_____ (AM/PM) we made a good faith attempt to obtain a written acknowledgement of receipt of our NPP, but acknowledgement could not be obtained because of the following reasons:

_____ Patient refused to sign
_____ Communication barriers prevented obtaining a receipt
_____ An emergency prevented obtaining a receipt
_____ Other: _____