Gastroenterology Specialists
of Southwest Florida
Diplomate, American Board of Internal Medicine and Gastroenterology

Steven A. Meckstroth, M.D.
William Gonzalez, PA-C
Karina Hooper, PA-C

E-mail: _____

Name: _____
Last First Middle Initial

Current Address: _____

_____

Northern Address: _____

Social Security#: _____ Marital Status: ☐ M ☐ S ☐ W ☐ D, Sex: ☐ M ☐ F

Date of Birth: _____

Home Phone: _____ Cell Phone: _____

Northern Phone: _____ Work Phone: _____

Employer: _____ Occupation: _____

In case of emergency please list a name, relationship and phone number OTHER than the above numbers

_____

Referring Doctor: _____ Phone: _____

Primary Care Doctor: _____ Phone: _____

Pharmacy

Primary Insurance Company Name: _____

Subscriber: _____ Subscriber Date of Birth: _____

Secondary Insurance Company Name: _____

Subscriber: _____ Subscriber's Date of Birth: _____

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PATIENT CONSENT FORM HIPAA COMPLIANT

With my consent, Gastroenterology Specialists of Southwest Florida, P.A. ("The Practice"), may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

I have the right to review the notice of privacy practices prior to signing this consent. The practice reserves the right to revise its notice of privacy practices at any time. A revised notice of privacy practices may be obtained by forwarding a written request to the practice at the address listed on this form.

With my consent, the practice may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory results, among others. With my consent, the practice may mail or email to my home, or other designated location, any items that assist the practice in carrying out TPO, such as appointment reminders, patient's statements and others.

I have the right to request that the practice restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to the practice's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, the practice may decline to provide treatment to me.

I wish to allow the following person(s) access to my medical record.

Name	Relationship
Name	Relationship

Signature: _____ Date: _____

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INSURANCE:

It is the patient's responsibility to know the terms of their insurance policy. It is the patient's responsibility to check to see whether Gastroenterology Specialists is in network with their plan. _____

If the patient's insurance plan is terminated after we have checked their eligibility or if their employer terminates their coverage retroactively, the patient will be responsible for the balance. _____

PAYMENT:

Unless other payment arrangements are approved by Gastroenterology Specialists in writing, the balance is due and payable when the patient's statement is issued and past due if not received within 30 (thirty) days of the issue date on the statement. The patient's responsibility will be the amount indicated on the patient's statement under "pay this amount". We reserve the right to add any fees incurred by us for additional billing and collection services. For the patient's convenience, we accept Visa, MasterCard, Discover, bank debit cards and personal checks. There is a $15.00 fee for any check returned by the patient's bank. If necessary, we can set up a regular payment schedule. This form acknowledges that the patient has given us permission to report the patient's account status to any credit agency such as a credit bureau if the agreed upon amount is not paid each month. The patient understands that if the account is submitted to an attorney or collection agency, or results in litigation, or if the past due amount is reported to a credit reporting agency, the fact that the patient has received treatment services at our office may become a matter of public record. Nonpayment of overdue balances may jeopardize continued care with Gastroenterology Specialists of Southwest Florida, P.A. _____

APPOINTMENTS:

If the patient is unable to keep their appointment, the patient must give 24 hour notice. Otherwise, a charge of $60.00 will apply. The patient's insurance will not cover this fee and the patient will be responsible for the fee. _____

RECORDS:

All requests for medical records must be requested in writing with a medical release form.

By signing below, the patient acknowledges and agrees to all of the terms and conditions contained herein and this agreement will become effective on the date indicated below.

Patient's Name:_____

Responsible Party:_____ _____ __ _____

Signature of Patient or Responsible Party:_____Date:_____